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SUPREME COURT
OF THE
STATE OF CONNECTICUT

S.C. 20765

KRISTIN MILLS, ADMINISTRATOR

v.

HARTFORD HEALTHCARE CORP. ET AL.

BRIEF OF THE PLAINTIFF-APPELLANT

To Be Argued By
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Statement of the issues

A. Did the trial court improperly conclude that Governor Lamont's Executive Order No. 7V, relating to the provision of health care services in support of the State's COVID-19 response, provided the defendant physicians with immunity from suit for their negligent misdiagnosis of the decedent's heart attack, where the decedent did not have COVID-19 and the standard of care and hospital protocols required the defendants to determine the need for emergency cardiac treatment without regard to a patient's COVID-19 status?

B. Did the trial court improperly determine that the defendants' administration of a COVID-19 test to the decedent provided the defendants with immunity from suit under the federal PREP Act, 42 U.S.C. § 247d-6d, where the COVID-19 test did not cause the decedent's injuries?

C. Did the trial court improperly grant in part the defendants' motion to dismiss the plaintiff's wrongful death action where the issue of the defendants' good-faith belief that the decedent might have been infected with COVID-19 was intertwined with the merits of whether the defendants negligently misdiagnosed the decedent's heart attack?

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I. Introduction

The plaintiff's decedent, Cheryl Mills,[1] was transferred from Backus Hospital in Norwich to Hartford Hospital in March of 2020 when she exhibited symptoms that led Backus Hospital staff to believe she was experiencing a life-threatening heart attack known as an ST elevation myocardial infarction[2] (STEMI). At Hartford Hospital, which is operated by the defendant Hartford Healthcare Corporation (HHC), the individual defendant doctors disagreed with the Backus staff, misdiagnosed Mills with conditions (myocarditis and myopericarditis) different from a STEMI, and accordingly, decided not to admit Mills promptly to the hospital's Catheterization Lab (Cath Lab), where she would have received life-saving treatment representing the standard of care for patients suffering a STEMI. Specifically, the standard of care for treating patients suffering from an acute STEMI is treatment in the Cath Lab within ninety minutes. Instead, the defendants admitted Mills to the hospital's general unit, where she remained under observation for more than four days before staff found her dead on the floor of her hospital room bathroom. The cause of death was in fact a myocardial infarction.

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[1] The plaintiff, Kristin Mills, is the administrator of the estate of Cheryl Mills; Clrk_Appx at 9; as well as Cheryl Mills' daughter. For simplicity, the decedent, Cheryl Mills, if referred to throughout this brief as Mills.

[2] "Myocardial infarction" is the medical term for what is known in common parlance as a heart attack. "Myocardial infarction." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriamwebster.com/dictionary/myocardial%20infarction. Accessed 23 Dec. 2022.

The defendants moved to dismiss the wrongful death action the plaintiff brought upon these facts for lack of subject matter jurisdiction. Although the plaintiff did not ever have COVID-19, and the complaint makes no mention of COVID-19, the defendants asserted immunity from suit in Mills' case under Executive Order No. 7V, which granted immunity to health care professionals and facilities for "injury or death alleged to have been sustained because of . . . acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response." The defendants submitted evidence that they believed at the time of their treatment of Mills that she might be ill with a virus, which in turn might have been COVID-19, and that, accordingly, they decided not to admit Mills to the Cath Lab, but instead chose to place her under observation and await results from a COVID-19 test, which took several days. The trial court concluded that, because the doctors believed in good faith that there was a possibility that Mills had COVID-19, they were immune from suit for all acts or omissions taken before Mills' negative COVID-19 test results came back three days after her admission to the hospital. The court further concluded that the loss alleged by the plaintiff (i.e., Mills' death) was caused by, arose out of, related to, or resulted from the administration of the COVID-19 test and, therefore, that the defendants are immune pursuant to the federal PREP Act, 42 U.S.C. § 247d-6d (a) (1).

The trial court erred in its conclusions. Specifically, the trial court improperly construed Executive Order No. 7V as providing immunity whenever doctors had a good faith belief that a patient might have COVID-19, rather than, consistent with the plain language of the executive order, only while doctors were providing what objectively constituted health care services in support of the State's COVID-19 response. Indeed, the trial court's interpretation of the

Executive Order would be unconstitutionally impermissible, as it would extend the immunity beyond the governor's power to issue such emergency orders as are reasonably necessary to protect the health, safety, and welfare of the people of this state, and, instead, would provide a variable and unpredictable immunity delineated by the subjective speculation and fears of each individual health care provider, which would cause the immunity to extend into considerable areas of health care actually unrelated to the COVID-19 pandemic.

When the appropriate objective standard is applied, the undisputed evidence in his case demonstrates that the defendants were not providing health care services in support of the state's COVID-19 response when they misdiagnosed Mills upon her arrival at HHC. In fact, the general standard of care prevailing during the COVID-19 pandemic, as well as HHC's own protocols at the time, required the prompt referral of patients presenting with symptoms of a STEMI to the Cath Lab within ninety minutes for life-saving treatment, irrespective of their COVID-19 status. In other words, there is no dispute that, where a patient required immediate emergency treatment in the Cath Lab, whether or not the patient had COVID-19 was irrelevant to the standard of care. Accordingly, the health care services the defendants performed upon Mills' arrival at HHD, namely, determining whether she was experiencing a STEMI that required immediate referral to the Cath Lab, had nothing to do with COVID-19, and accordingly, did not constitute "health care services in support of the State's COVID-19 response." Additionally, the trial court was factually mistaken in concluding that the administration of a COVID-19 test caused Mills' injuries; the undisputed factual record establishes instead that the doctors' initial misdiagnosis of Mills caused their decision to delay her life-saving treatment.

Accordingly, the trial court's decision granting the defendants' motion to dismiss in part should be reversed.

II. Nature of Proceedings and Statement of Fact

The plaintiff filed the eight-count complaint on November 5, 2020, alleging the following facts. The defendant Hartford Healthcare Corporation (HHC) is a Connecticut corporation that owns Hartford Hospital, which has cardiology specialists among the services it offers to the public. Clrk_Appx at 9.[3] The individual defendants Asad Rizvi, Melissa Ferraro-Borgida, Brett Duncan, and William Farrell were employed by HHC as cardiologists. Clrk_Appx at 10, 14-15, 19, 23.

On March 21, 2020, at approximately 12:08 p.m., the plaintiff's decedent, Cheryl Mills, underwent an electrocardiogram (EKG) at Backup Hospital in Norwich. The EKG revealed rapid atrial fibrillation and ST elevation. Clrk_Appx at 10. The Backus Hospital Emergency Department determined that Mills was critically ill with a high probability of imminent or life-threatening deterioration. Clrk_Appx at 11. Specifically, Backus Hospital emergency physician Theresa Adams suspected that Mills was experiencing an ST elevation myocardial infarction (STEMI). Clrk_Appx at 10. The treatment for a STEMI, an emergency cardiac catheterization known as percutaneous coronary intervention (primary PCI), was not available at Backus Hospital, however, so Adams called Hartford Hospital to arrange that Mills be transferred to Hartford Hospital's Catheterization Lab (Cath Lab), where there was a staff dedicated exclusively to performing cardiac catheterization procedures. Clrk_Appx at 10. The Cath Lab

[3]Except for those facts related solely to an individual physician-defendant, the allegations are repeated in each count of the complaint. For simplicity, citations included here are to the first appearance of the particular allegation.

held itself out as a "life-saving cardiac unit" for patients who—exactly like Cheryl Mills—were "experiencing cardiac emergencies in local community hospitals without catheterization labs." Clrk_Appx at 10-11.

Within a few minutes of Mills' EKG, Adams spoke with Rizvi, who was the on-call attending physician at the Cath Lab. Clrk_Appx at 11. When Rizvi expressed the opinion that Mills' symptoms were not consistent with STEMI, Adams sent him a copy of the EKG along with an earlier EKG for comparison. Clrk_Appx at 11. Adams also reported to Rizvi that Mills' troponin level was 8.6. Clrk_Appx at 11. Mills was transported by ambulance to Hartford Hospital at about 1:14 p.m. for emergent care and treatment at the Cath Lab. Clrk_Appx at 11. When she arrived at Hartford Hospital, in addition to the EKG suggesting an inferolateral STEMI and a troponin level of 8.6, Mills was reporting neck pain and headaches. Clrk_Appx at 11. At Hartford Hospital, Mills was given another EKG, which, like the one performed at Backus Hospital, showed ST elevation. Clrk_Appx at 11. The following alert was issued: "** ** ACUTE MI / STEMI ** **." Clrk_Appx at 11. By 2:15 p.m., a physician at Hartford Hospital's emergency room determined that Mills was critically ill with a high probability of imminent or life-threatening deterioration, exactly as the Backus Hospital Emergency Hospital had previously determined. Clrk_Appx at 11.

At 2:50 p.m., Rizvi declined to transfer Mills to the Cath Lab. Clrk_Appx at 12. At 3:11 p.m., her troponin level was 4 and her BNP level was markedly elevated, consistent with acute decompensated heart failure. Clrk_Appx at 12. At 3:27 p.m., however, Rizvi diagnosed Mills with myopericarditis and determined that cardiac catheterization should be deferred. Clrk_Appx at 12. Twenty-five minutes later, a bedside echocardiogram showed inferior wall motion abnormalities

consistent with a STEMI. Clrk_Appx at 12. At 5:12 p.m., Ferraro-Borgida reviewed Mills' history, labs, EKGs, and echocardiogram, diagnosed her with suspected acute myocarditis,[4] and determined that cardiac catheterization should be deferred. Clrk_Appx at 17. At 9:29 p.m., Mills' troponin level was 21.84. Clrk_Appx at 12. Mills was admitted to the general unit of Hartford Hospital that evening. Clrk_Appx at 12. She remained hospitalized there for roughly three and one-half more days, during which time she was never seen, evaluated, or treated in the Cath Lab. Clrk_Appx at 12.

At 9:08 a.m. on March 22, 2020, Mills' second day at Hartford Hospital, Duncan reviewed her history, labs, EKGs, and echocardiogram, diagnosed her with likely myocarditis, and determined that cardiac catheterization should be deferred. Clrk_Appx at 21. Similarly, on Mills' third day at Hartford Hospital, March 23, 2020, at 10:50 a.m., Farrell reviewed her case, diagnosed her with likely myocarditis, and declined to transfer her to the Cath Lab. Clrk_Appx at 25. It was only upon a review at 2:03 p.m. of the fourth day, March 24, 2000, that Farrell recognized the need for Mills to be transferred to the Cath Lab. Clrk_Appx at 25. Nevertheless, he deferred the transfer to the fifth day, March 25, 2020. Clrk_Appx at 25. That very next morning, March 25, 2020, however, before she ever

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[4] Myocarditis is inflammation of the myocardium, the middle muscular layer of the heart wall. Myopericarditis is inflammation of both the myocardium and pericardium, the conical sac of serous membrane that encloses the heart and the roots of the great blood vessels of vertebrates. See definitions of "myocardium," "myocarditis," "myopericarditis," and "pericardium," Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary. Accessed 23 Dec. 2022.

made it to the Cath Lab, Mills went into cardiac arrest, was found without a pulse on the floor of her hospital room bathroom, and was pronounced dead at 7:39 a.m. Clrk_Appx at 12. Her death certificate indicates her cause of death as myocardial infarcation. A57.

The plaintiff alleges that Mills' injuries and death were caused by the negligence and gross negligence of HHC and the individual defendants in numerous ways, including, inter alia, that they: misdiagnosed her with both myopericarditis and myocarditis; failed to diagnose her with a myocardial infarction despite rising and/or falling cardiac biomarkers, ST elevations on multiple EKGs, and new regional wall motion abnormalities on an echocardiogram; unreasonably delayed cardiac catheterization; failed to immediately transfer her to the Cath Lab for primary PCI; and failed to properly monitor her when she was suffering from a life-threatening condition. Clrk_Appx at 12-13. As a result, she suffered severe, serious, permanent and painful injuries, which resulted in emotional distress, mental anguish and, ultimately, her death.[5]

In the opinion letter filed in support of the plaintiff's complaint as required by General Statutes § 52-190a (a), the authoring provider indicates that when Mills was admitted to Hartford Hospital, "[t]he attending cardiologist diagnosed her with myopericarditis and not with

[5]From this common set of historical facts, the specific counts of the complaint, all of which are brought pursuant to the wrongful death statute, General Statutes § 52-555, are as follows. Counts I through IV allege negligence by HHC and Rizvi (count I), HHC and Ferraro-Borgida (count II), HHC and Duncan (count III), and HHC and Farrell (count IV). Counts V through VIII allege gross negligence by HHC and Rizvi (count V), HHC and Ferraro-Borgida (count VI), HHC and Duncan (count VII), and HHC and Farrell (count VIII).

an acute STEMI as suggested by all of the information available to him . . . ." Clrk_Appx at 34-35. The provider further indicates that "[t]he applicable standard of care for cardiologists requires that they appropriately diagnose individuals with cardiac emergencies, that they rule out life-threatening conditions on the differential diagnosis, that they perform appropriate testing to reach a diagnosis, that they rapidly diagnose individuals who have ST-segment elevation in two or more contiguous leads, troponin elevation, and regional wall abnormalities on echocardiography with ST elevation myocardial infarction (STEMI), that they immediately treat individuals suffering from STEMI with primary PCI in the Cath Lab, with a goal 'door-to-balloon' time of less than 90 minutes, and that they appropriately monitor individuals suffering from STEMI." Clrk_Appx at 35. "Had [Mills] undergone emergent primary PCI on 3/21/20 upon arrival to Hartford Hospital, as the standard of care required, she would not have died and her life expectancy would have been normal." Clrk_Appx at 35-36.

On January 13, 2021, all of the defendants filed motions, pursuant to Practice Book § 10-30, to dismiss the respective counts of the complaint brought against them. See Clrk_Appx at 38-42. Specifically, the defendants moved to dismiss all counts of the complaint for lack of subject matter jurisdiction, claiming to be immune from suit on the basis of both Connecticut state law and federal law. As a state law basis, the defendants relied on Governor Ned Lamont's Executive Order No. 7V (Order 7V) of April 7, 2020, which provides immunity for acts or omissions of health care providers providing health care services in support of Connecticut's COVID-19 response. As a federal law basis, the defendants relied on the Public Readiness and Emergency Preparedness Act (PREP Act), 42 U.S.C. § 247d-6d et seq., which, inter alia, provides immunity for losses caused

by "covered countermeasures" in the event of a declaration of a public health emergency.

In support of the motions to dismiss, the defendants submitted an affidavit of Rizvi, in which he explains what he was thinking at the time of his treatment of Mills: Rizvi "knew that certain viral infections can cause myocarditis and myopericarditis and in turn cause patients' EKG results to demonstrate ST elevation"; A59; he was "aware that certain patients afflicted with COVID-19 could present with ST elevation and abnormal troponin levels secondary to COVID-induced myocarditis or myopericarditis"; A59; he "believed, based on [his] medical training and expertise, that Ms. Mills could be experiencing a cardiac inflammatory condition such as myocarditis or myopericarditis secondary to a viral syndrome, and that this viral syndrome was possibly COVID-19"; A59; and he "determined, based on [his] medical training and expertise, that the most prudent course of action in light of the infectious disease protocols at the time given the COVID-19 treatment environment was to delay Ms. Mills' admission to the Cath Lab pending receipt of the results of a COVID-19 test that was administered to her shortly after her arrival to Hartford Hospital." A60. Ferraro-Borgida and Duncan submitted affidavits, worded identically, in which they both indicated that when they became involved with Mills' case, Rizvi had already put a plan in place "to defer cardiac catheterization until receipt of the pending COVID-19 test results, that Ferraro-Borgida and Duncan "in good faith, agreed with the plan," and that "COVID-19 was a primary factor in [their] diagnostic assessment of COVID-19 caused myocarditis versus acute coronary syndrome." A63, A67-68.

In support of their motions to dismiss, the defendants also relied on an affidavit of Dr. Adam Steinberg, HHC's Vice President for Medical Affairs, Hartford Region. In the affidavit, Steinberg indicated

that at the time of the events in question, HHC was providing health care services in support of the state's response to COVID-19, including treatment of patients infected with or suspected of being infected with COVID-19, and was taking steps to limit its spread. A70. HHC was also engaged in efforts to conserve personal protective equipment, including limiting contact between patients and hospital personnel. A70. Steinberg further indicated that HHC had "modified its protocols to . . . avoid admitting patients who were suspected of having COVID-19 to Hartford Hospital's Cardiac Catheterization lab (the "Cath Lab") until they had tested negative, **unless their physical symptoms dictated the need for emergency catheterization**." (Emphasis added.) A70. In other words, HHC's own evidence established that, under HHC's own established COVID-19 protocols, patients whose physical symptoms dictated the need for emergency catheterization would be admitted to the Cath Lab even if they were suspected of having COVID-19 and even if they had not yet tested negative for COVID-19.

In opposition to the defendants' motions to dismiss, the plaintiff submitted, inter alia, the affidavit of Dr. Emil R. Hayek, who is board-certified in cardiovascular disease, nuclear cardiology, echocardiology, and internal medicine. Hayek, who reviewed the medical records in the present case, attested to the following. Mills was suffering an acute STEMI, which was misdiagnosed as myopericarditis and/or myocarditis. Myopericarditis and myocarditis are not life-threatening emergencies, and the standard of care for their treatment is supportive medical care, not immediate treatment in the Cath Lab. The standard of care for treating a patient suffering an acute STEMI like Mills, on the other hand, is percutaneous coronary intervention in the Cath Lab, with a goal of "door-to-balloon" time of less than ninety minutes, along with appropriate monitoring. Additionally, the standard treatment for

a STEMI has not changed during the COVID-19 pandemic, and patients suffering an acute STEMI are seen on an emergent basis in the Cath Lab, regardless of their COVID-19 status, for primary percutaneous coronary intervention. A73. Accordingly, the plaintiff's medical expert, Hayek, agreed with the defendants' Vice President, Steinberg, that COVID-19 had not changed the protocols requiring patients needing emergency catheterization to be transferred to the Cath Lab irrespective of their COVID-19 status.

In its September 27, 2021 memorandum of decision, the trial court, *Budzik, J.*, granted the defendants' motions to dismiss in part and denied them in part. Central to the trial court's decision was its conclusion that "the defendants had a good faith belief that they may be treating an actual COVID-19 patient." Clrk_Appx at 49. Although all parties had presented evidence establishing that COVID-19 status would play no role in determining whether a patient with symptoms of an acute STEMI would be sent to the Cath Lab, the court concluded that "the undisputed facts demonstrate that the delay in Ms. Mills' transfer to Hartford Hospital's cardiac catheterization lab was the direct result of a delay in the reporting of Ms. Mills' COVID-19 test results and the defendants' good faith concern that Ms. Mills' symptoms were being caused by COVID-19." Clrk_Appx at 44. Based on that reasoning, the court went on to conclude that the defendants were immune from suit under Order 7V for negligence occurring before Mills' negative COVID-19 test result at 7:40 p.m. on March 24, 2020. Clrk_Appx at 49-50. Similarly, the court concluded that Mills' COVID-19 test was a covered countermeasure under the federal PREP Act, that all of the plaintiff's claims based on acts or omissions prior to 7:40 p.m. on March 24, 2020, arose from the COVID-19 test, and that, accordingly, the defendants are immune from suit for such acts. Clrk_Appx at 51-52. The court further concluded that the immunity

afforded by the PREP Act applied to both the plaintiff's gross negligence claims in addition to the ordinary negligence claims. Clrk_Appx at 52. Finally, the court concluded that, once Mills received a negative COVID-19 test at 7:40 p.m. on March 24, 2020, the defendants could no longer claim the protection of the immunity provisions because their actions after that time were not related to COVID-19 or COVID-19 testing. Clrk_Appx at 50, 52.

Following motions for clarification filed by the parties; see Clrk_Appx at 54-60; the trial court held a hearing and issued an order on November 2, 2021, specifying that, because Rizvi, Ferraro-Borgida, and Duncan did not provide any care to Mills after 7:40 p.m. on March 24, 2020, the counts against them and HHC based on their actions were fully dismissed from the case. Clrk_Appx at 61. Accordingly, the court clarified that it was dismissing I, II, III, V, VI, and VII. Clrk_Appx at 61. Counts IV and VIII against HHC and Farrell, accordingly, remain pending.

This appeal followed.[6]

III. Argument

A. Standard of Review

"We engage in **plenary** review of a trial court's grant of a motion to dismiss for lack of subject matter jurisdiction. (Emphasis added.) *Mendillo v. Tinley, Renehan & Dost, LLP*, 329 Conn. 515, 523, 187 A.3d 1154, 1159 (2018).

B. The trial court improperly dismissed in part the plaintiff's complaint on the ground that the defendants were immune from suit under Executive Order No. 7V

[6]HHC and Dr. Farrell have brought separate appeals from the denial of their motions to dismiss. See S.C. 20763 and S.C. 20764.

1. The trial court misconstrued the plain language of Executive Order No. 7V as providing immunity whenever doctors believe in good faith that there is a mere possibility that a patient has COVID-19

The crux of the trial court's conclusion that the defendants were immune under Order 7V was that the defendants reasonably believed that there was a **possibility** that Mills had COVID-19. Specifically, the trial court determined that the defendants were immune under Order 7V because Dr. Rizvi "believed Ms. Mills might be suffering from COVID-19"; Clrk_Appx at 48; that "the defendants' [sic] had a good faith belief that they may be treating an actual COVID-19 patient"; id. at 49; that "Ms. Mills could not say that she was not exposed to COVID-19 at her job registering patients at Backus Hospital's ER and it was an entirely reasonable concern on the part of Dr. Rizvi and the defendants that Ms. Mills may have been exposed to COVID-19 in that role"; id., 49-50; and that "it was a reasonable concern on the part of Dr. Rizvi and the defendant that Ms. Mills' granddaughter's respiratory virus may have been a missed case of COVID-19, particularly in the early days of the pandemic when comparatively little was known about COVID-19." Id., 50. The trial court's conclusion that the immunity provided by Order 7V applies to any actions taken based on a reasonably belief that a patient might possibly have COVID-19 is not supported by its plain language.

Although Order 7V is an executive order, rather than a statute, in interpreting its language, this Court should apply its well established rules of statutory construction, as it does to a wide array of legislative and quasi-legislative enactments. Cf. *Teresa T. v. Ragaglia*, 272 Conn. 734, 751, 865 A.2d 428 (2005) (state agency regulations construed in accordance with rules of statutory construction); *Smith v.*

Zoning Board of Appeals, 227 Conn. 71, 89, 629 A.2d 1089 (1993) (general rules of statutory construction apply to interpretation of zoning regulations), cert. denied, 510 U.S. 1164, 114 S. Ct. 1190, 127 L. Ed. 2d (1994). Applying ordinary rules of statutory construction to executive orders promulgated by the governor under a legislative delegation of authority is appropriate because, like state agency regulations, executive orders have "the force and effect of law." (Internal quotation marks omitted.) See *Teresa T. v. Ragaglia*, supra, 751 (Supreme Court construes administrative rules and regulations win accordance with accepted rules of statutory construction because they are given force and effect of law). Accordingly, the examination of the executive order should begin with its plain text, construing words and phrases according to commonly approved usage, and, if the text is plain and unambiguous, it should be applied as written. See, e.g., *Rutter v. Janis*, 334 Conn. 722, 730, 224 A.3d 525 (2020).

Executive Order No. 7V (6) provides in relevant part:

> Notwithstanding any provision of the Connecticut General Statutes or any other state law, including the common law, or any associated regulations, rules, policies, or procedures, any health care professional or health care facility shall be immune from suit for civil liability for any injury or death alleged to have been sustained because of the individual's or health care facility's **acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response**, including but not limited to acts or omissions undertaken because of a lack of resources, attributable to the COVID-19 pandemic, that renders the health care professional or health care facility unable to provide the level or manner of care that otherwise would have been required in the absence of the COVID-19 pandemic and which resulted in the damages at issue,

> provided that nothing in this order shall remove or limit any immunity conferred by any provision of the Connecticut General Statutes or other law. Such immunity shall not extend to acts or omissions that constitute a crime, fraud, malice, gross negligence, willful misconduct, or would otherwise constitute a false claim or prohibited act pursuant to Section 4-275 et seq. of the Connecticut General Statutes or 31 U.S.C. §§3729 et seq. The term 'health care professional' means an individual who is licensed, registered, permitted, or certified in any state in the United States to provide health care services and any retired professional, professional with an inactive license, or volunteer approved by the Commissioner of the Department of Public Health or her designee. The term 'health care facility' means a licensed or state approved hospital, clinic, nursing home, field hospital or other facility designated by the Commissioner of the Department of Public Health for temporary use for the purposes of providing essential services in support of the State's COVID-19 response. The immunity conferred by this order applies to acts or omissions subject to this order occurring at any time during the public health and civil preparedness emergency declared on March 10, 2020, including any period of extension or renewal, including acts or omissions occurring prior to the issuance of this order attributable to the COVlD-19 response effort."

(Emphasis added.) Executive Order No. 7V (6).

The key language at issue here is "acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response." The trial court interpreted this language to confer immunity when doctors **believe** in good faith that they may be treating a patient with COVID-19. That, however, is not a natural reading of the language. Specifically, the governor's order does not use

the language "good faith belief" or "believes in good faith." Rather, it refers to "acts or omissions undertaken in good faith." In other words, the language regarding good faith is not connected with a belief in any particular facts or state of affairs, but simply indicates that the relevant acts or omissions must have been undertaken in good faith. Accordingly, the phrase "in good faith" describes simply the state of mind of the defendants during the relevant acts or omissions, and does not suggest that immunity applies whenever a doctor in good faith believed a patient might have COVID-19.

Presumably, had the governor intended to provide an immunity that applied whenever a defendant acted with a good-faith belief that a patient had COVID-19, Order 7V would have set forth language clearly reflecting that intent. The blueprint for such language readily exists, as our laws do contain precisely this type of provision in statutes governing various types of immunity. For example, General Statutes § 52-557v provides immunity to a person who "provides or administers an epinephrine cartridge injector to an individual whom the person believes in good faith is experiencing anaphylaxis . . . ." General Statutes § 52-557v (a) and (b). General Statutes § 19a-909 (f) (2) sets provides similar immunity where a "person in training believes in good faith" that someone "is experiencing anaphylaxis . . . ." Our state statute governing actions for equitable relief or damages for deprivations of equal protection uses similar language; it provides that "governmental immunity shall only be a defense to a claim for damages when, at the time of the conduct complained of, the police officer had an objectively good faith belief that such officer's conduct did not violate the law." General Statutes § 52-571k (d) (1). Accordingly, there is an obvious, established way—essentially, a template—for setting forth language indicating that immunity applies to individuals when they undertake actions or omissions with a good-

faith belief in a particular state of affairs.[7] Yet, the governor did not include language here expressly immunizing health care workers who act in a good-faith belief that a patient might have COVID-19.

Instead of immunizing acts or omissions undertaken with a good-faith belief that a patient might have COVID-19, the governor immunized "acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response." The plain meaning of this language is that immunity applies to acts or omissions undertaken in good faith, so long as they are undertaken while providing health care services in support of the state's COVID-19 response. In other words, the plain language sets forth two discrete conditions that must be met. While the immunity afforded by Order 7V applies where the relevant acts or omissions were undertaken "in good faith," such good faith alone is insufficient to confer immunity. The

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[7] Even outside of the particular context of immunity, our laws make reference to situations where individuals are explicitly authorized to take particular actions related to health if they possess specified good-faith beliefs. See, e.g., General Statutes § 7-294u (b) (police officer completing designated training may carry and administer opioid antagonist to individual whom officer believes in good faith is experiencing opioid-related drug overdose); General Statutes § 52-146c (c) (3) (permitting psychologist to disclose communications relating to patient "[i]f the psychologist believes in good faith that there is a risk of imminent personal injury . . ."). Indeed, a search of the General Statutes using the phrases "good faith belief" and "believes in good faith" reveals dozens of instances where this type of straightforward language had been used to clearly and effectively convey this concept.

acts or omissions must also have been undertaken while providing health care services in support of the State's COVID-19 response. Accordingly, immunity will not apply if the acts or omissions were undertaken in bad faith. Similarly, the immunity does not extend to any acts or omissions if the health care services being provided were not "in support of the State's COVID-19 response."

Such a reading is consistent with the "last antecedent rule, which this court has applied on numerous occasions . . . ." *L.H.-S. v. N.B.*, 341 Conn. 483, 492, 267 A.3d 178 (2021). Under that rule, "[r]eferential and qualifying words and phrases, where no contrary intention appears, refer solely to the last antecedent. The last antecedent is the last word, phrase, or clause that can be made an antecedent without impairing the meaning of the sentence." Id. Here, where Order 7V refers to "acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response," the word "undertaken" (the past participle of the verb "undertake") is the last antecedent for both the phrase "in good faith" and the subsequent adverbial clause "while providing health care services in support of the State's COVID-19 response." Thus, both phrases refer to the manner in which the acts or omissions must be undertaken in order to qualify for immunity, and both conditions must be satisfied. In order to determine whether the trial court properly determined that the conditions for the application of Order 7V's immunity were satisfied in the present case, therefore, this Court must examine the meaning of each of these requirements.

With regard to the Order's good faith requirement, as previously observed, the governor did not attach the concept of good faith to any particular belief. Rather, the requirement is simply that the acts or omissions were undertaken "in good faith . . . ." This Court has had occasion to consider what it means for particular conduct to have been

carried out in good faith, and it has done so in the specific context of immunity—more particularly, immunity from liability for malicious prosecution, where "a proper concern for private assistance to public law enforcement officers requires immunity from liability for malicious prosecution for the citizen who, in good faith, volunteers false incriminating information." (Internal quotation marks omitted.) *Bhatia v. Debek*, 287 Conn. 397, 412, 948 A.2d 1009 (2008). In determining what "good faith" means in the context of such immunity, this Court elaborated:

> We have never defined the term "good faith" in this context, but understand it to be used in its traditional sense. The Appellate Court explained this common meaning aptly in *Kendzierski v. Goodson*, 21 Conn. App. 424, 574 A.2d 249 (1990), and we now adopt that definition. "In common usage, the term good faith has a well defined and generally understood meaning, being ordinarily used to describe that state of mind denoting honesty of purpose, freedom from intention to defraud, and, generally speaking, means being faithful to one's duty or obligation. [35 C.J.S., Faith 605 (1960)] and cases cited. It has been well defined as meaning [a]n honest intention to abstain from taking an unconscientious advantage of another, even through the forms or technicalities of law, together with an absence of all information or belief of facts which would render the transaction unconscientious . . . . It is a subjective standard of honesty of fact in the conduct or transaction concerned, taking into account the person's state of mind, actual knowledge and motives. . . . Whether good faith exists is a question of fact to be determined from all the circumstances." . . . *Kendzierski v. Goodson*, supra 429-30.

Bhatia v. Debek, supra, 287 Conn. 412-13.

Our courts have subsequently looked to that definition to inform their construction of "good faith" provisions in statutes that, similarly to Order 7V, do not set forth a specific definition of good faith, and have concluded that the phrase has an established and unambiguous meaning. For example, in *Deas v. Diaz*, 132 Conn. App. 146, 30 A.3d 23, cert. denied, 303 Conn. 920, 34 A.3d 392 (2012), the Court endeavored to construe a provision of General Statutes § 52-572h that referred to "good faith efforts by [a] claimant to collect from a liable defendant." Id., 151-52. Although the Court noted that the statutes did not define "good faith efforts," it concluded that "because 'good faith' has a common legal meaning . . . the phrase is clear and unambiguous," and went on to apply the definition quoted above from *Bhatia v. Debek*. *Deas v. Diaz*, supra, 132 Conn. App. 152. Cf. *PSE Consulting, Inc. v. Frank Mercede and Sons, Inc.*, 267 Conn. 279, 304-305, 838 A.2d 135 (2004) (Connecticut's conception of bad faith in various contexts requires improper motive or dishonest purpose, the conscious doing of a wrong because of dishonest purpose or moral obliquity, or a state of mind affirmatively operating with furtive design or ill will).

As noted, however, good faith alone is not sufficient to confer immunity under Order 7V. The acts or omissions must also have been undertaken by the individual or health care facility "while providing health care services in support of the State's COVID-19 response." The plain meaning of the word "while" is durational; it means "[a]s long as; during the time that." American Heritage Dictionary of the English Language (3d Ed. 1992). Accordingly, the immunity afforded by Order 7V applies only to acts or omissions undertaken during such times as the defendants were actually providing health care services in support of the State's COVID-19 response. It follows that they are not immune from suit for acts or omissions they undertook while they were

providing other health care services, i.e., those that were not in support of the State's COVID-19 response.

That the immunity Governor Lamont afforded health care providers in his emergency COVID-19 orders would extend only to acts or omissions undertaken while actually providing those health care services that specifically supported the state's COVID-19 response, but not while undertaking other health care services, is fully in accord with the principles this Court recently articulated regarding the scope of the governor's emergency powers in *Casey v. Lamont*, 338 Conn. 479, 258 A.3d 647 (2021). There, this Court concluded that the emergency powers the legislature conferred on the governor through General Statutes § 28-9 (b) (1) and (7), and which Governor Lamont specifically exercised in response to the COVID-19 pandemic, did not constitute an unconstitutional delegation of powers in violation of the separation of powers provision of the Connecticut constitution. Id., 502-23. In so concluding, this Court provided important clarification of the scope of the governor's powers under the statute.

Among the important limitations on the governor's emergency powers this Court cited in *Casey* is the principle that the governor's "actions are limited to those that are **reasonably necessary** to protect the health, safety, and welfare of the people of this state." (Emphasis in original.) Id., 508. "Moreover, the governor may act only to the extent that the health, safety, and welfare of the people are implicated by this **particular** serious disaster." (Emphasis in original.) Id. In other words, the governor cannot constitutionally use the authorization of emergency powers under § 28-9 to usurp the legislature's function and legislate in ways that are not specifically tailored to addressing the effects of the present pandemic:

> The governor would not, for example, be able to issue an executive order forbidding restaurants from selling unhealthy foods during

> the COVID-19 pandemic. Although eating healthy foods is undoubtedly related to the health and welfare of the people of this state, such an action is not reasonably necessary to address the current pandemic. Likewise, should a hurricane of sufficient severity require the governor to proclaim a civil preparedness emergency, mandating that Connecticut citizens wear masks would not be a proper action under subsection (b) (7) merely because it might have the incidental health benefit of reducing the spread of the common cold. Rather, the governor's actions under subsection (b) (7) must be reasonably necessary to address the specific serious disaster that warranted the civil preparedness emergency proclamation.

Casey v. Lamont, supra, 338 Conn. 508-509.

This Court must be mindful of that important constitutional limitation when it construes Order 7V. Indeed, "[i]t is . . . well settled that [t]his court should try, whenever possible, to construe statutes to avoid a constitutional infirmity, but may not do so by rewriting the statute or by eschewing its plain language." (Internal quotation marks omitted.) *Walsh v. Jodoin*, 283 Conn. 187, 199, 925 A.2d 1086 (2007). Any interpretation of Order 7V that would view it as setting forth orders "not reasonably necessary to address the specific serious disaster that warranted the civil preparedness emergency proclamation [the COVID-19 pandemic]"; *Casey v. Lamont*, supra, 338 Conn. 509; would render it unconstitutional. Just as, in the examples given in *Casey*, the governor would lack the constitutional authority to outlaw unhealthy foods under the guise of responding to the COVID-19 crisis and to mandate the wearing of masks as part of a hurricane response, the governor would lack the constitutional authority to extend immunity through Order 7V to health care workers for acts or omissions that are not related to the COVID-19 pandemic. Thus, for

example, the governor would clearly lack the authority to use the COVID-19 pandemic as an opportunity to give healthcare workers general immunity from suit for negligence in the treatment of novel viruses other than COVID-19, not to mention matters entirely unlike COVID-19—setting broken bones or delivering newborns, for example. By the same token, to keep Order 7V within constitutional limitations, this Court must interpret it as extending immunity only for those acts or omissions specifically related to the COVID-19 pandemic. Fortunately, such an interpretation is fully consistent with Order 7V's plain language that the immunity it provides applies to "acts or omissions undertaken . . . while providing health care services in support of the State's COVID-19 response."

Interpreting Order 7V in a way that limits the immunity it confers to only those situations in which health care providers are actually providing health in specific support of the state's COVID-19 response also comports with the well-established principle that laws are "construe[d] . . . in a manner that will not . . . lead to absurd results." (Internal quotation marks omitted.) *Raftopol v. Ramey*, 299 Conn. 681, 703, 12 A.3d 783 (2011). The trial court's broader interpretation that the immunity applied whenever a health care provider believed a patient might have COVID-19 would potentially extend immunity to a wide range of crucial emergency situations, similar to Mills' in the present case, in which patients without COVID-19 were denied life-saving treatment. For example, under the trial court's interpretation, doctors would be immune where a patient died after being admitted to the emergency room with a life-threatening gunshot wound, if doctors, upon learning information indicating the patient might have COVID-19, nevertheless decided to isolate the patient rather to prevent spread of the virus than rushing the patient into life-saving surgery. Similarly, doctors would have immunity where

a patient arriving with life-threatening injuries from a car accident was denied life-saving emergency treatment because the doctors, upon learning that other passengers in the vehicle had COVID-19, placed the patient in isolation to await the results of the COVID-19 test. In short, the delivery of life-saving emergency treatment for medical conditions entirely unrelated to COVID-19 cannot rationally be considered "health care services in support of the State's COVID-19 response" simply because a doctor fears that a patient might have COVID-19. Such an interpretation would effectively confer a blanket immunity on hospital operations during the early stages of the COVID-19 pandemic, when rapid COVID-19 testing was unavailable and virtually every patient coming through a hospital's or doctor's officer's doors could have been infected with the COVID-19 virus.

Such a breathtaking scope of immunity, however, goes far beyond the purposes of Order 7V. The purposes of the immunity provision of Order 7V are most fully set forth in the various explanatory preambles set forth in Executive Order No. 7U, which section 6 of Order 7V replaced.[8] In those preambles, the governor observed that "in order to respond adequately to the public health emergency posed by the COVID-19 pandemic, it has been necessary to

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[8] See Executive Order No. 7V (6), providing in relevant part: "Section 1 of my prior Executive Order No. 7U concerning protection from civil liability for actions or omissions in support of the State's COVID-19 response is hereby superseded and replaced in its entirety by the following . . . ." The difference between the original immunity provision of Order 7U and the substituted provision in 7V was to clarify that the immunity applied notwithstanding not only provisions of the General Statutes, but "any other state law, including the common law," as well.

supplement Connecticut's health care workforce and the capacity of health care facilities **to deliver life-saving care** by requesting the assistances of health care professionals who have not previously maintained liability coverage; facilitating the deployment of volunteer and out-of-state healthcare professionals; and calling upon healthcare professionals to perform **acts that they would not perform in the ordinary course of business** . . . ." (Emphasis added.) If the ultimate interest served by the immunity was the support of health care facilities "to deliver life-saving care," an interpretation of that immunity that would extend to decisions not to deliver life-saving care out of generalized fears of COVID-19 would be counterproductive. Additionally, the above-quoted language indicates that immunity was viewed as necessary to protect health care workers from facing liability for acts that they would not perform in the ordinary course of business outside the context of the COVID-19 pandemic. Extending the immunity to negligence in the ordinary provision of life-saving medical treatments unrelated to COVID-19 does not advance that purpose.

The need to reasonably contain the operation of Order 7V within constitutional parameters also suggests that, unlike the good faith requirement, which is subjective, whether acts or omissions have been undertaken by doctors "while providing health care services in support of the State's COVID-19 response" should be determined under an objective standard. That is, to determine whether acts or omissions are within the scope of the immunity, the court should determine whether they were undertaken while providing the particular type of health care services that actually constituted part of the state's COVID-19 response, rather than those services that particular doctors subjectively believed might be related to COVID-19. Such a conclusion is supported not only by the aforementioned absence of any "good faith belief" language in Order 7V, but by the absence of any other language

indicative of a subjective standard. The present language differs from provisions this Court has previously found to contain a subjective element, such as in *General Motors Corp. v. Dohmann*, 247 Conn. 274, 286-87, 722 A.2d 1205 (1998). There, this Court determined that Connecticut's lemon law incorporated a standard that was in part subjective when it referred to "any defect or condition which substantially impairs the . . . value of the motor vehicle to the consumer." Id., 286. This Court noted that "[t]he phrase 'to the consumer' . . . suggests that the needs and expectations of the individual consumer should be considered in a determination of whether a defect has substantially impaired the value of a vehicle," and, thus, "suggests . . . a subjective component . . . ." Id., 287. No language similarly suggestive that anyone's subjective concerns or fears about COVID-19 should be taken into account is used in Order 7V. See also *K.D. v. D.D.*, 214 Conn. App. 821, 829-31, 282 A.3d 528 (2022) (applying objective standard in the absence of statutory language indicating legislative intent to incorporate subjective element).

In short, the trial court misconstrued the plain language of Order 7V. It viewed the provision as providing immunity whenever health care providers believed in good faith that there was a possibility a patient might have the COVID-19 virus. Instead, it should have examined, in addition to good faith, whether, objectively, the acts or omissions were undertaken while the defendants were providing health care services in support of the State's COVID-19 response.

2. The undisputed facts in the record establish that the defendants were not providing health care services in support of the state's COVID-19 response when they misdiagnosed the decedent.

This Court, in its past decisions, has extensively articulated the standards to be applied by trial courts in ruling on motions to dismiss civil complaints for lack of subject matter jurisdiction. The leading case establishing the operative facts for a motion to dismiss is *Conboy v. State*, 292 Conn. 642, 974 A.2d 669 (2009). There, this Court explained:

> Trial courts addressing motions to dismiss for lack of subject matter jurisdiction pursuant to § 10–31 (a) (1) may encounter different situations, depending on the status of the record in the case. . . .
>
> [L]ack of subject matter jurisdiction may be found in any one of three instances: (1) the complaint alone; (2) the complaint supplemented by undisputed facts evidenced in the record; or (3) the complaint supplemented by undisputed facts plus the court's resolution of disputed facts. . . . Different rules and procedures will apply, depending on the state of the record at the time the motion is filed.
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> When a trial court decides a jurisdictional question raised by a pretrial motion to dismiss on the basis of the complaint alone, it must consider the allegations of the complaint in their most favorable light. . . . In this regard, a court must take the facts to be those alleged in the complaint, including those facts necessarily implied from the allegations, construing them in a manner most favorable to the pleader. . . .
>
> In contrast, if the complaint is supplemented by undisputed facts established by affidavits submitted in support of the motion to dismiss; Practice Book § 10–31 (a); other types of undisputed evidence . . . and/or public records of which judicial notice may be taken . . . the trial court, in determining the jurisdictional issue, may consider these supplementary undisputed facts and need not conclusively presume the validity of the allegations of the

> complaint. . . . Rather, those allegations are tempered by the light shed on them by the [supplementary undisputed facts]. . . . If affidavits and/or other evidence submitted in support of a defendant's motion to dismiss conclusively establish that jurisdiction is lacking, and the plaintiff fails to undermine this conclusion with counteraffidavits; see Practice Book § 10–31 (b); or other evidence, the trial court may dismiss the action without further proceedings. . . . If, however, the defendant submits either no proof to rebut the plaintiff's jurisdictional allegations . . . or only evidence that fails to call those allegations into question . . . the plaintiff need not supply counteraffidavits or other evidence to support the complaint, but may rest on the jurisdictional allegations therein. . . .
>
> Finally, where a jurisdictional determination is dependent on the resolution of a critical factual dispute, it cannot be decided on a motion to dismiss in the absence of an evidentiary hearing to establish jurisdictional facts. . . . Likewise, if the question of jurisdiction is intertwined with the merits of the case, a court cannot resolve the jurisdictional question without a hearing to evaluate those merits. . . . An evidentiary hearing is necessary because a court cannot make a critical factual [jurisdictional] finding based on memoranda and documents submitted by the parties.

(Citations omitted; footnotes omitted; internal quotation marks omitted.) *Conboy v. State*, supra, 292 Conn. 650–54.

In the present case, the defendants' own evidence in support of their motions to dismiss established that, even under HHC's COVID-19 protocols in place at the time of Mills' admission to Hartford Hospital, the determination of whether a patient was exhibiting physical symptoms dictating the need for emergency catheterization

was made without regard to the patient's COVID-19 status. Specifically, Vice President for Medical Affairs Adam Steinberg's affidavit indicated that HHC had "modified its protocols to . . . avoid admitting patients who were suspected of having COVID-19 to Hartford Hospital's Cardiac Catheterization lab (the "Cath Lab") until they had tested negative, **unless their physical symptoms dictated the need for emergency catheterization**." (Emphasis added.) A70. In other words, the defendants' own evidence in support of their motion to dismiss established that patients whose physical symptoms dictated the need for emergency catheterization did not have to receive a negative COVID-19 test result before being admitted to the Cath Lab.

That evidence was not disputed by any other evidence in the record. On the contrary, the plaintiff's evidence was in full accord with the defendants' evidence on this point. Specifically, Dr. Hayek's affidavit confirmed that the standard of care for treating a patient suffering an acute STEMI is percutaneous coronary intervention in the Cath Lab within 90 minutes of entering the hospital, along with appropriate monitoring. A73. Hayek also attested, in agreement with the defendants' evidence from Steinberg, to the fact that that the standard of treatment for a STEMI did not change during the COVID-19 pandemic, and patients suffering an acute STEMI continued to be seen on an emergent basis in the Cath Lab for percutaneous coronary intervention, regardless of their COVID-19 status. A73.

Both the plaintiff's and the defendants' affiants, accordingly, were in agreement that the decision of whether someone was suffering a cardiac emergency requiring immediate treatment in the Cath Lab was one that continued, even during those early days of the COVID-19 pandemic, to be made without consideration of a patient's COVID-19 status. The critical nature of such a cardiac emergency outweighed

COVID-19 considerations, both as a matter of the general standard of care that prevailed in the medical profession, and as a matter of HHC's own internal protocols.

These evidentiary submissions by the parties being properly before the court[9] and undisputed, the trial court was not at liberty to disregard them. As *Conboy* makes clear, "where a jurisdictional determination is dependent on the resolution of a critical factual dispute, it cannot be decided on a motion to dismiss in the absence of an evidentiary hearing to establish jurisdictional facts." *Conboy v. State*, supra, 292 Conn. 652. A credibility determination is, of course, a hallmark of, and essential aspect of, fact finding. See, e.g., *Ravetto v. Triton Thalassic Technologies, Inc.*, 285 Conn. 716, 728, 941 A.2d 309 (2008) (province of fact finder to weigh evidence and determine credibility and effect to be given to evidence and credibility must be assessed not by reading cold printed record but by observing firsthand witness' conduct, demeanor and attitude). Accordingly, any decision by the trial court not to credit undisputed evidence in an affidavit could not be made without an evidentiary hearing on the critical factual question of credibility. Cf. *Suarez v. Dickmont Plastics Corp.*, 229 Conn. 99, 107, 639 A.2d 507 (1994) (credibility was issue for finder of fact which could not be resolved by trial court on summary judgment).

Additional facts were undisputed in the present case because they were set forth in the complaint and were not the subject of any supplemental evidence submitted by the parties. After the Backus Hospital staff suspected Mills was experiencing a STEMI, they determined was critically ill with a high probability of imminent or life-threatening deterioration and arranged to have her transferred to

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[9] There were no objections in the trial court to the admissibility of the affidavits or to their form or contents.

HHC, where there was a Cath Lab that could perform a primary PCI. Clrk_Appx at 10-11. At the time, she had an elevated troponin level and an EKG had issued an alert of " ** **ACUTE MI / STEMI ** **." Id. at 11. But Rizvi diagnosed Mills, not with STEMI, but with myopericarditis and declined transfer of Mills to the Cath Lab. Id. at 12. Subsequently, Ferraro-Borgida, Duncan, and Farrell all diagnosed Mills with myocarditis and determined that cardiac catheterization should be deferred. Id. at 17, 21, 25. The doctors' diagnoses of Mills with myocarditis and myopericarditis were in fact misdiagnoses; id., 12-13; the doctors failed to timely diagnose Mills with a STEMI despite numerous medical indicators; id., 13; they unreasonably delayed cardiac catheterization; id.; and they failed to immediately transfer Mills to the Cath Lab for primary PCI. Id. Additionally, the complaint specifically alleges that all those failures on the part of the doctors were "departures from the applicable standard of care." Id., 12.

Accordingly, for purposes for the motions to dismiss, the trial court was bound, and this Court is likewise bound, to assume the truth of the plaintiff's allegations that the defendants misdiagnosed Mills with myocarditis and myopericarditis rather than a STEMI and that they unreasonably delayed her cardiac catheterization and failed to send her immediately to the Cath Lab, all in violation of the applicable standard of care, unless undisputed evidence submitted in connection with the motions establishes that these facts are not true. The evidence submitted by the parties, however, does nothing to contradict those facts alleged in the complaint.

First, the evidence submitted does nothing to dispute the plaintiff's allegations that the diagnosis of Mills with myocarditis and myopericarditis rather than a STEMI was a misdiagnosis. Rizvi's affidavit explains what he was thinking at the time of his treatment of Mills: he "knew that certain viral infections can cause myocarditis and

myopericarditis and in turn cause patients' EKG results to demonstrate ST elevation"; A59; he was "aware that certain patients afflicted with COVID-19 could present with ST elevation and abnormal troponin levels secondary to COVID-induced myocarditis or myopericarditis"; A59; he "believed, based on [his] medical training and expertise, that Ms. Mills could be experiencing a cardiac inflammatory condition such as myocarditis or myopericarditis secondary to a viral syndrome, and that this viral syndrome was possibly COVID-19"; A59; and he "determined, based on [his] medical training and expertise, that the most prudent course of action in light of the infectious disease protocols at the time given the COVID-19 treatment environment was to delay Ms. Mills' admission to the Cath Lab pending receipt of the results of a COVID-19 test that was administered to her shortly after her arrival to Hartford Hospital." A60. While these statements explain **what** Rizvi thought was happening on, or, more precisely, what he thought "could be" or "possibly" was happening with Mills, they say nothing about whether Rizvi was correct, nor whether he breached any applicable standards of care.

Ferraro-Borgida's and Duncan's affidavits likewise do not contradict the complaint's allegations of misdiagnosis and negligence. They establish that the doctors "in good faith, agreed with the plan" already put in place by Rizvi to defer cardiac catheterization and wait instead of COVID-19 test results, and that "COVID-19 was a primary factor in [their] disgnostic assessment of COVID-19 caused myocarditis versus acute coronary syndrome." A63, A67-68. Nothing in the affidavits shed any light on whether Ferraro-Borgida and Duncan were correct in their diagnoses nor whether they adhered to the applicable standard of care.

In the absence of any evidence contradicting the plaintiff's well-pleaded allegation that the myocarditis and myopericarditis diagnoses were misdiagnoses, the *Conboy* standards dictate that the trial court and this Court must treat those well-pleaded allegations of misdiagnosis as true for purposes of the motions to dismiss. Moreover, Hayek's affidavit supports the allegation that Rizvi, Ferraro-Borgida, and Duncan in fact did misdiagnose Mills when they concluded she was not suffering a STEMI. Hayek plainly attests that, based upon his review of the records, Mills was suffering a STEMI when she was admitted to Hartford Hospital, that Mills was misdiagnosed with myopericarditis. The record does not include any evidence contradicting the allegations and evidence indicating that Mills was actually having a STEMI, that she did not have myocarditis or myopericarditis, and that the doctors breached the standard of care by not getting her into the Cath Lab within ninety minutes.

In this regard, it is important to note that the doctors' references in their affidavits to "good faith" are not equivalent to reasonable care. As previously discussed, good faith is a subjective state of mind indicating the absence of bad faith or an improper motive. See *PSE Consulting, Inc. v. Frank Mercede and Sons, Inc.*, supra, 267 Conn. 304-305 (Connecticut's conception of bad faith in various contexts requires improper motive or dishonest purpose, the conscious doing of a wrong because of dishonest purpose or moral obliquity, or a state of mind affirmatively operating with furtive design or ill will). The question of whether a party has exercised reasonable care, meanwhile, is an objective test concerned not with the actor's state of mind but whether the actor has complied with prevailing standards. See *Osborn v. Waterbury*, 333 Conn. 816, 220 A.3d 1 (2019) (citing "general principle that the standard of care in a negligence action is an objective one, determined by external standards"). That is, good faith is not the

conceptual or legal equivalent of compliance with the medical standard of care. See also *Funding Consultants, Inc. v. Aetna Casualty & Surety Co.*, 187 Conn. 637, 642-43, 447 A.2d 1163 (1982) (good faith means honesty in fact in the conduct or transaction concerned and imposes no duty of due care).

Thus, although the affidavits mention good faith, they make no attempt to offer any guidance on whether the doctors' diagnoses were in conformity with the applicable medical standards of care. No standards of care are defined in the affidavits. Nor do the doctors provide any evaluation or opinion of whether their conduct actual was in conformity with any standards of care. None of the other evidence submitted in connection with the motions to dismiss addresses this question either. Accordingly, in the absence of evidence setting forth undisputed facts regarding whether the doctors complied with an applicable medical standard of care, the complaint's allegations of breach of the standard of care, for purposes of the present motions to dismiss, must be viewed in the light most favorable to the plaintiff and must be considered true under the standards set forth by this Court in *Conboy*.

The foregoing discussion, then, establishes certain undisputed key facts the trial court was bound by, under the *Conboy* rules defining the factual basis for deciding motions to dismiss, and the factual record in the present case: (1) the determination of whether a patient was experiencing physical symptoms such as a STEMI that dictated the need for emergency catheterization, and thus immediate referral to the Cath Lab, was determination that was made, even during the COVID-19 pandemic, without regard to a patient's COVID-19 status, both as a matter of the general medical standard care and under the specific protocols in place at Hartford Hospital; (2) Mills was in fact experiencing a STEMI in the present case when she was admitted to

Hartford Hospital; (3) the defendants' diagnosis of Mills with myocarditis and/or myopericarditis rather than a STEMI was a misdiagnosis; and (4) that misdiagnosis was a departure from the applicable standard of care. Taken together, these facts establish that, if the doctors had not negligently misdiagnosed Mills, they would have recognized that she was experiencing a STEMI, a procedure that required an immediate (within ninety minutes) transfer to the Cath Lab for treatment **irrespective** of her COVID-19 status. Thus, under these undisputed facts, the reason Mills was not quickly transferred to the Cath Lab was because the defendants negligently misdiagnosed her with myocarditis and myopericarditis rather than a STEMI. In other words, but for the misdiagnosis, Mills' COVID-19 status would have been considered irrelevant, and the fact that she was experiencing a STEMI would have compelled the defendants to get her into the Cath Lab quickly.

The key conclusion of the trial court from which its entire decision granting the motions to dismiss in favor of Rizvi, Ferraro-Borgida, and Duncan (as well as HHC in part), however, was to the contrary. Specifically, the trial court concluded: "[T]he undisputed facts demonstrate that the delay in Ms. Mills' transfer to Hartford Hospital's cardiac catheterization lab was the direct result of a delay in the reporting of Ms. Mills' COVID-19 test results and the defendants' good faith concern that Ms. Mills' symptoms were being caused by COVID-19." Clrk_Appx at 44. That conclusion gets the causation wrong under the undisputed facts. The delay in sending Mills to the Cath Lab, premised as it was on a belief that her COVID-19 status was even relevant, was itself a result of the defendants' negligent misdiagnosis. That is, waiting for the COVID-19 test results did not cause the delay; had the defendants recognized that Mills was having a STEMI, her COVID-19 status would not have been a consideration in

whether she would have been sent immediately to the Cath Lab. Accordingly, it was only because of their negligent misdiagnosis that they waited for the COVID-19 results. The defendants' own initial misdiagnosis caused them to even take Mills' COVID-19 status into account, and, thus, wait for the results of the COVID-19 test, and, thus, was the actual cause of the delay.

What this all amounts to is that the defendants' acts and omissions, when they made the initial misdiagnosis of Mills, were not undertaken "while providing health care services in support of the State's COVID-19 response." They were doing exactly what they would have always done with a patient such as Mills even before the COVID-19 pandemic: determining whether she was exhibiting physical symptoms dictating the need for immediate emergency catheterization. In other words, they were performing an ordinary medical function unconnected with COVID which, under their own protocols, had to be undertaken irrespective of Mills' COVID-19 status. This is not a case in which the defendants were actually treating COVID-19, a situation in which they would certainly be immune. Nor is this a case in which the defendants were following protocols that had been altered in good faith as part of Hartford Hospital's COVID-19 response, a situation that would also afford immunity. On the contrary, this is a case in which the protocols for diagnosing and treating a non-COVID-19 condition dictated business as usual and the defendants departed from those protocols solely as the result of their own negligent misdiagnosis. As previously discussed, a proper construction of Order 7V dictates that its immunity cannot extend to such situations. Because these acts and omissions were not undertaken while providing health care services in support of Connecticut's COVID-19 response, an essential condition for Order 7V's immunity to apply was not satisfied, and the

trial court improperly dismissed the complaint in part on the basis of that executive order.

C. The trial court improperly dismissed in part the plaintiff's complaint on the ground that the defendants were immune from suit under the federal PREP Act

The federal PREP Act, 42 U.S.C. § 247d-6d (a) (1) provides in relevant part that "a covered person shall be immune from suit and liability under Federal and State law with respect to all claims for loss caused by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure if a declaration . . . has been issued with respect to such countermeasure." The trial court concluded that the defendants are immune from suit under that provision because the COVID-19 test that the defendants administered to Mills was a covered countermeasure and was the actual cause of Mills' injuries. Specifically, the trial court concluded that "[t]he gravamen of the [plaintiff's] claim is that the defendants' [sic] delayed Ms. Mills [sic] care for a heart attack because the defendants' [sic] mistakenly thought Ms. Mills had COVID-19. The reasons why the defendants' [sic] thought Ms. Mills had COVID-19 from March 21st to March 24th arose out of and was related to the fact that they were awaiting the results of a COVID-19 diagnostic test, a 'covered countermeasure' under the PREP Act." Clrk_Appx at 52. The trial court's conclusion is supported neither by the case law that has developed interpreting the PREP Act during the COVID-19 pandemic, nor by the factual record in the present case, nor by simple logic.

The body of federal case law on the PREP Act that has developed during the COVID-19 pandemic makes clear that the immunity it affords is only available when the claim or loss at issue

was caused by the administration or use of the particular countermeasure. "In sum, the PREP Act creates immunity for all claims of loss causally connected to the administration or use of covered countermeasures . . . ." *Saunders v. Big Blue Healthcare, Inc.*, 522 F. Supp. 3d 946 (D. Kan. 2021). The requirement of such a causal connection is set forth in the plain language of the statute itself. See 42 U.S.C. § 247d-6d (a) (2) (B) ("[t]he immunity under paragraph (1) applies to any claim for loss that has a causal relationship with the administration to or use by an individual of a covered countermeasure"). Accordingly, for the immunity to apply, "there **must be** a causal relationship between an injury and the administration or use by an individual of a covered countermeasure." (Emphasis in original; internal quotation marks omitted.) *Mitchell v. Advanced HCS, LLC*, 28 F.4th 580 (5th Cir. 2022). The countermeasure here relied on by the defendants was the COVID-19 test they administered to Mills. Accordingly, for the PREP Act immunity to apply, Mills' injuries would have to have been caused by the COVID-19 test.

First and foremost, the trial court's reasoning that such causation was established was flawed because the undisputed factual record, as already discussed in the preceding section of this brief, demonstrates that the delay in getting Mills into the Cath Lab was caused not by the COVID-19 test, but by the defendants' initial misdiagnosis of Mills. Had the defendants initially properly diagnosed her with a STEMI, she would have been rushed into the Cath Lab irrespective of her COVID-19 status because, as the defendants' own evidence indicated, the initial question of whether Mills was experiencing a STEMI, and thus, whether she required immediate treatment in the Cath Lab, was a matter that did not properly involve consideration of her COVID-19 status. Whether she had COVID-19 was entirely irrelevant to that decision. It was that initial misdiagnosis

that led the doctors to delay sending her to the Cath Lab; the wait for the COVID-19 test results, thus, resulted from those initial misdiagnosis-related decisions and did not itself cause the delay. Thus, it was not the COVID-19 test, but the defendants' initial misdiagnosis, that caused Mills' injuries. The wait for the COVID-19 test was incidental to the decision to delay that that the defendants had already made.

This conclusion is supported by basic principles of causation as espoused frequently by this Court. "[C]ause in fact, occasionally referred to as actual cause, asks whether the defendant's conduct 'caused' the plaintiff's injury. Thus, if the plaintiff's injury would not have occurred 'but for' the defendant's conduct, then the defendant's conduct is a cause in fact of the plaintiff's injury. Conversely, if the plaintiff's injury would have occurred regardless of the defendant's conduct, then the defendant's conduct was not a cause in fact of the plaintiff's injury. [W. Keeton et al., Prosser and Keeton on the Law of Torts] (5th Ed. 1984) § 41, p. 266." *Snell v. Norwalk Yellow Cab, Inc.*, 332 Conn. 720, 743-44, 212 A.3d 646 (2019). Thus, it is helpful to ask whether Mills' death would have occurred "but for" the COVID-19 test in the present case.

As previously discussed, the defendants' initial misdiagnosis of Mills' STEMI was what caused the delay in sending her to the Cath Lab. The COVID-19 test was just a means to receive later confirmation or disconfirmation of that initial decision. In short, the decision not to get Mills into the Cath Lab within the ninety-minute window for life-saving treatment was the cause of Mills' injuries. Once that initial negligence took place, and Mills had failed to receive the emergency medical treatment she needed, the administration of the COVID-19 test made her death neither more nor less likely. Thus, there is no basis for a conclusion that she would have survived "but for" the

administration of the COVID-19 test. The requisite "causal relationship" required for PREP Act immunity under 42 U.S.C. § 247d-6d (a) (1) and (2) (B) is entirely absent from this case.

Furthermore, the trial court's conclusion that "the reason why the defendants' [sic] thought Ms. Mills had COVID-19 . . . arose out of and was related to the fact that they were awaiting the results of the COVID-19 diagnostic test" flies in the face of logic. Clrk_Appx at 52. A doctor's own act of administering a diagnostic test to a patient does not make the doctor believe the patient has the tested-for condition. Rather, the doctor's concern that the patient may have the condition (or the simple desire to rule out the condition) precedes, and provides the impetus for, the administration of the test. Certainly, there is nothing in the record in the present case to suggest that the fact that the defendants were awaiting the results of Mills' COVID-19 was "the reason why the [defendants] thought . . . Mills had COVID-19." To be sure, Rizvi's affidavit indicates that he "determined, based on [his] medical training and expertise, that the most prudent course of action in light of the infectious disease protocols at the time given the COVID-19 treatment environment was to delay Ms. Mills' admission to the Cath Lab pending receipt of the results of a COVID-19 test." In other words, Rizvi undoubtedly made a decision not to admit Mills to the Cath Lab until he received the results of her COVID-19 test. That, however, is not the equivalent of the COVID-19 test **causing** Rizvi (or the other defendants) to believe that Mills had COVID-19. In other words, the doctors administered the COVID-19 test because they suspected Mills might have the virus; the trial court's reasoning inexplicably reversed that causation to conclude that the doctors thought Mills had the virus because they had given her the test.

In short, the case law, the factual record in the present case, and sound logic all indicate that the trial court improperly concluded that

there was a causal relationship between Mills' injuries and the COVID-19 test the defendants gave her. Accordingly, this Court should reverse the trial court's dismissal of the complaint in part on the basis of the PREP Act.

D. Even if the defendants' belief that the decedent might have COVID-19 was relevant, it presented an issue of fact requiring denial of the motions to dismiss

The plaintiff has argued in the preceding sections of this brief that the defendants' subjective mistaken belief that Mills may have had COVID-19 was not relevant to determining whether they were immune from suit under Order 7V and the PREP Act. Should this Court determine, however, that their subjective belief was relevant, the standards set forth by this Court for resolution of issues of subject matter jurisdiction would still not permit the granting of the motion to dismiss based on that belief. That is because the issue of the defendants' good faith belief that Mills might have had COVID-19 was intertwined with the merits of the case, and, under this Court's precedents, a motion to dismiss must be denied where the issues are so intertwined.

As this Court held in *Conboy v. State*, supra 292 Conn. 642: "[W]here a jurisdictional determination is dependent on the resolution of a critical factual dispute, it cannot be decided on a motion to dismiss in the absence of an evidentiary hearing to establish jurisdictional facts." (Internal quotation marks omitted.) Id., 652. "A preliminary evidentiary hearing ordinarily will suffice where the jurisdictional issue is distinct and severable from the merits of the action, for example, when personal jurisdiction is called into question." Id., 653 n.15. However, "if the question of jurisdiction is intertwined with the merits of the case, a court cannot resolve the jurisdictional question

without a hearing to evaluate those merits. . . . An evidentiary hearing is necessary because a court cannot make a critical factual [jurisdictional] finding based on memoranda and documents submitted by the parties." (Internal quotation marks omitted.) Id., 653-54.

In *Conboy*, the plaintiffs brought an action to recover damages from the state of Connecticut for violation of General Statutes § 31-51q, which prohibits the discharge or discipline of employees for exercising certain constitutional rights. Id., 644 and n.3. The state moved to dismiss the claims against it for lack of subject matter jurisdiction, arguing that the plaintiffs' claims did not come within the waiver of sovereign immunity conferred by that statute, and submitting documents that it claimed demonstrated that the plaintiffs were not disciplined or discharged but were instead laid off in response to economic pressures. Id., 645. Those documents were various public records showing the state was under serious budgetary pressures, which the state argued demonstrated that the plaintiffs' termination was part of a mass layoff not actionable under § 31-51q. Id., 647-48.

The trial court denied the motion to dismiss, concluding that, notwithstanding the defendant's documents, the plaintiffs' complaint "contain[ed] sufficient allegations to fall within the purview of § 31-51q . . . ." Id., 648. On appeal, this Court agreed that "on the record presented to the trial court, a factual dispute existed over the reason for the plaintiffs' loss of employment [and] the trial court properly declined to address the state's legal argument and denied its motion to dismiss." Id., 649. The Court noted that, "[i]n undertaking this review, we are mindful of the well established notion that, in determining whether a court has subject matter jurisdiction, every presumption favoring jurisdiction should be indulged." (Internal quotation marks omitted.) Id., 650. The Court continued:

> Here, the documents submitted by the state in support of its motion to dismiss demonstrate only that there was a fiscal crisis around the time the plaintiffs' employment was terminated and that some layoffs of state employees had occurred. At best, the documents raise an issue of fact and are not sufficient to refute the well pleaded allegations of the complaint that the termination of the plaintiffs' employment was threatened and effected in retaliation for their engaging in constitutionally protected activities. In short, the state, in pressing its motion to dismiss, relied solely on general background information as to the economic climate and budgetary challenges existing in fiscal year 2003, and provided no evidence to contradict specifically the allegations in the complaint supporting jurisdiction. It submitted no affidavits from, for example, individuals directly involved in the decision(s) to terminate the plaintiffs' employment explaining how those decisions were reached, no testimony to link the general budget adjustments suggested by the public documents to the particular loss of employment suffered by the plaintiffs, no employment records for the plaintiffs explaining the reasons for the termination of their employment or any other evidence to controvert the specific allegations of the complaint as to improper retaliatory action. Furthermore, there is no indication in the record that the state requested a hearing to present more specific, probative evidence.
>
> In sum, a critical factual dispute remains as to the reason for the termination of the plaintiffs' employment, and that dispute could not be resolved on the limited record before the trial court.

Id., 655–56.

Here, the jurisdictional issue is likewise intertwined with the merits of the case, and the documents submitted by the defendants are

insufficient to overcome the well-pleaded facts of the complaint as set forth earlier in this brief. Specifically, the plaintiff has alleged that the defendants were negligent in misdiagnosing Mills' STEMI as myocarditis and myopericarditis when she was initially admitted to HHC, thus leading them not to promptly admit her to the Cath Lab for emergency treatment, which ultimately led to her death. The defendants have responded by moving to dismiss for lack of subject matter jurisdiction, submitting evidence indicating that they believed Mills' symptoms might have been attributable to myocarditis or myopericarditis caused by COVID-19 rather than to a STEMI. But the defendants' claim that they held that belief in good faith is itself intertwined with questions at the center of the merits of the case, namely, the reasonableness of the defendants' initial evaluation and diagnosis of Mills when she was admitted to HHC.

Indeed, the inextricable nature of these issue is demonstrated by this Court's observation that, although good faith and reasonableness are not synonymous, the issues may inform each other. *PSE Consulting, Inc. v. Frank Mercede and Sons, Inc.*, supra, 267 Conn. 305 (whether surety's actions were reasonable may be considered when analyzing bad faith); see also *Funding Consultants, Inc. v. Aetna Casualty and Surety Co.*, supra, 187 Conn. 644 ("Although mere negligence or failure to make the inquiries which a reasonably prudent person would make does not itself amount to bad faith, if a party fails to make an inquiry for the purpose of remaining ignorant of facts which he believes or fears would disclose a defect in the transaction, he may be found to have acted in bad faith." [Internal quotation marks omitted.]). In short, a determination of whether the defendants believed in good faith that Mills' symptoms might have been caused by COVID-19 was inseparable from the merits question of whether the

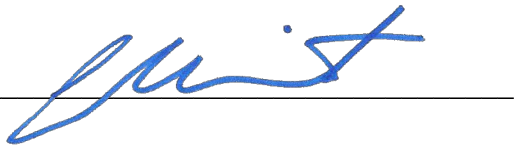
defendant performed a reasonable medical evaluation and diagnosis of Mills.

Because the trial court could not properly evaluate the defendants' jurisdictional claim that they believed in good faith that Mills' symptoms might have been caused by COVID-19 without also delving into the reasonableness of the defendants' diagnosis of Mills, the jurisdictional question was intertwined with the merits. Accordingly, under this Court's binding precedent in *Conboy*, the trial court was bound to deny the motion to dismiss. Accordingly, this Court should reverse the trial court's judgment dismissing the plaintiff's complaint in part.

IV. Conclusion

For all of the foregoing reasons, this Court should reverse the trial court's judgment to the extent that it granted the defendants' motions to dismiss in part and remand for further proceedings.

PLAINTIFF-APPELLANT,
KRISTIN MILLS

By 

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Certification

The undersigned attorney hereby certifies, pursuant to Connecticut Practice Book § 67-2A, that:

(1) the e-brief and appendix complies with all applicable Rules of Appellate Procedure, including § 67-2A;

(2) no deviations from § 67-2A were requested;

(3) this e-brief contains **13,343** words;

(4) the e-brief and party appendix and paper copies have been redacted or do not contain any names or other personal identifying information that is prohibited from disclosure by rule, statute, court order or case law;

(5) the paper brief and appendix being filed with the appellate clerk are true copies of the e-brief and appendix that were submitted electronically;

(6) the e-brief and appendix have been delivered electronically to the last known e-mail address of each counsel of record for whom an e-mail address has been provided:

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Filed Under the Electronic Briefing Rules

SUPREME COURT
OF THE
STATE OF CONNECTICUT

S.C. 20765

KRISTIN MILLS, ADMINISTRATOR

v.

HARTFORD HEALTHCARE CORP. ET AL.

APPENDIX TO BRIEF OF THE
PLAINTIFF-APPELLANT

APPENDIX TABLE OF CONTENTS

VS-4 REV. 1/04
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER (For State Use only. Do not write in this box)

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last): Cheryl Mills — Cheryl D. Mills
2. SEX: ☐ Male ☑ Female
3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Spell Month): 03/25/2020 March
4. ACTUAL OR PRESUMED TIME OF DEATH: 0739 ☑ AM ☐ PM
5. AGE LAST BIRTHDAY: 63
6. UNDER 1 YEAR: Mo. / Days
UNDER 1 DAY: Hours / Min.
7. DATE OF BIRTH: [redacted]
8. BIRTHPLACE (City, State or Foreign Country): Bridgeport, Connecticut
9. RESIDENCE (State): [redacted]
10. RESIDENCE (County): [redacted]
11. RESIDENCE (City or Town): C[redacted]
12. RESIDENCE (Street and No.): 4[redacted]
13. APT. NO.
14. ZIP CODE: 0[redacted]
15. EVER IN US ARMED FORCES? ☐ Yes ☒ No
16. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married but separated ☐ Widowed [redacted] ☐ Unknown
17. SURVIVING SPOUSE'S NAME (Give full name prior to first marriage)
18. FATHER'S NAME (First, Middle, Last): Peter Datzenko
19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Mildred Sepelak
20. INFORMANT'S NAME: ~~Kristen~~ Kristin Mills
21. INFORMANT'S RELATIONSHIP TO DECEDENT: Daughter
22. MAILING ADDRESS (Street and Number, City, State, Zip Code): 4[redacted]
23. IF DEATH OCCURRED IN A HOSPITAL: ☒ Inpatient ☐ ER/outpatient ☐ Dead on Arrival
24. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Other (specify)
25. FACILITY NAME (If not institution, give street & number): Hartford Hospital
26. CITY OR TOWN OF DEATH: Hartford — ZIP CODE: 06106
27. COUNTY OF DEATH: Hartford
28. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (specify)
29. DISPOSITION (Name of cemetery, crematory, other place): ☒ Mt. Grove Crematory
30. LOCATION (city/town, state): Bridgeport, Connecticut
31. DATE (MM/DD/YYYY): 03/27/2020
32. WAS BODY EMBALMED? If yes, Name of Embalmer ☐ Yes* ☒ No;
33. FUNERAL FACILITY Name and Address (street, town/state, zip): Stratford Connecticut 06614 Adzima Funeral Home 50 Paradise Green Pl.
34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER
35. LICENSE NUMBER OF SIGNEE IN BOX 34: 2675
36. DATE PRONOUNCED DEAD (MM/DD/YYYY): 03/25/2020
37. TIME PRONOUNCED: 0739
38. PRONOUNCER'S NAME AND DEGREE OR TITLE (Print): Jordan Kunkes MD
39. PRONOUNCER'S SIGNATURE
40. DATE SIGNED: 03/25/2020
41. WAS MEDICAL EXAMINER CONTACTED? ☐ Yes ☒ No
42. WAS AN AUTOPSY PERFORMED? ☐ Yes ☑ No
43. WERE THE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

CAUSE OF DEATH

44. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		APPROXIMATE INTERVAL ONSET TO DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death)	(a) Myocardial Infarction	Days
Sequentially list conditions, if any, leading to the cause listed on line (a). Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(b) Coronary Artery Disease	Years
	(c)	
	(d)	

45. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. Aortic Stenosis
46. IF FEMALE: ☒ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year
47. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☒ Unknown

48. CERTIFIER (Check only one box) ☐ Certifying practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge death occurred due to the cause(s) and manner stated. ☒ Pronouncing & Certifying Practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated.
Certifier Name (Type or Print): Jordan Kunkes — Certifier Signature — Title of Certifier: MD — Date Certified: 03/25/2020
49. MAILING - CERTIFIER: 95 Seymour (Street) Street — Hartford (City or Town) — CT (State) — 06106 (Zip)

THIS CERTIFICATE WAS RECEIVED FOR RECORD ON: MAR 27 2020 — BY REGISTRAR — 2020

50. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.
☐ 8th grade or less ☐ 9th - 12th grade, no diploma ☐ High School Graduate/GED ☐ Some college credit, but no degree ☐ Associate degree ☒ Bachelor's degree ☐ Master's degree ☐ Doctorate or Professional degree ☐ Unknown ☐ Not available

51. DECEDENT OF HISPANIC ORIGIN? ☒ No, Not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (specify)

52. DECEDENT'S RACE ☒ White ☐ Black or African American ☐ Asian Indian ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify) ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (specify) ☐ Other (specify)

53. DECEDENT'S USUAL OCCUPATION: ER Registrar
54. KIND OF BUSINESS/INDUSTRY: William W. Backus Hospital
55. SOCIAL SECURITY NUMBER: 048-40-7336

For use by Physician or Institution
Name of Decedent: Cheryl D Mills

"SEAL"

I CERTIFY THAT THIS IS A TRUE COPY OF THE CERTIFICATE AS RECORDED IN THIS OFFICE:

ATTESTED: _____ REGISTRAR OF VITAL STATISTICS"

DATED: March 31, 2020 CITY OF "HARTFORD CONNECTICUT"

NOT VALID WITHOUT SEAL OF THE "HARTFORD HEALTH DEPARTMENT"

DOCKET # HHD-CV20-6134761-S	:	SUPERIOR COURT
	:	
KRISTIN MILLS, ADMINISTRATOR OF THE ESTATE OF CHERYL MILLS,	:	J.D. OF HARTFORD
Plaintiff,	:	
	:	
v.	:	AT HARTFORD
	:	
HARTFORD HEALTHCARE CORPORATION, d/b/a HARTFORD HOSPITAL; ASAD RIZVI, M.D.; MELISSA FERRARO-BORGIDA, M.D.; BRETT H. DUNCAN, M.D.; and WILLIAM FARRELL, M.D.,	:	
Defendants.	:	JANUARY 13, 2021

AFFIDAVIT OF ASAD RIZVI, M.D.

I, Asad Rizvi, M.D., being duly sworn, depose and state:

1. I am over the age of eighteen (18) and understand the obligations of an oath.

2. I am a physician licensed to provide health care services in the State of Connecticut. I am currently employed as an interventional cardiologist at Hartford Hospital in Hartford, Connecticut, and in that position work within Hartford Hospital's cardiac catheterization laboratory (the "Cath Lab").

3. I make this affidavit in support of Hartford HealthCare Corporation d/b/a Hartford's Hospital's and my motion to dismiss the complaint filed by Kristin Mills, Administrator of the Estate of Cheryl Mills, in the above-captioned action. This affidavit is based on my own personal knowledge, as well as my review of certain medical records produced during or otherwise relating to the treatment period at issue in this lawsuit.

4. I provided medical treatment to Plaintiff's Decedent, Cheryl Mills ("Ms. Mills") on March 21, 2020. Specifically, my treatment involved corresponding with Ms. Mills's treating physician in the Backus Hospital Emergency Department (the "Backus ED") regarding Ms.

Mills's clinical presentation; reviewing the results of Ms. Mills's clinical tests, including electrocardiogram (EKG) results and echocardiogram results; personally examining Ms. Mills upon her arrival to Hartford Hospital; and recommending a COVID-19 test for Ms. Mills based upon her presentation.

5. Based on my medical training and experience, I know that certain viral infections can cause myocarditis and myopericarditis and in turn cause patients' EKG results to demonstrate ST elevation.

6. At the time I provided medical treatment to Ms. Mills, I was aware that certain patients afflicted with COVID-19 could present with ST elevation and abnormal troponin levels secondary to COVID-induced myocarditis or myopericarditis.

7. At the time I provided medical treatment to Ms. Mills, the Cath Lab, along with Hartford Hospital generally, had implemented certain protocols and procedures intended to minimize staff exposure to patients possibly infected with COVID-19 and preserve personal protective equipment ("PPE"), as well as to avoid cross-infecting patients who were not infected with COVID-19.

8. Based on the entirety of Ms. Mills's clinical presentation while I was treating her, including, but not limited to, her high risk for exposure to COVID-19 based on her employment as a registrar in the Backus ED, the nature and duration of symptoms upon presentation which were consistent with a viral infection, and the notable absence of cardiac symptoms upon presentation, I believed, based on my medical training and expertise, that Ms. Mills could be experiencing a cardiac inflammatory condition such as myocarditis or myopericarditis secondary to a viral syndrome, and that this viral syndrome was possibly COVID-19.

9. Given my concern that Ms. Mills was infected with COVID-19, combined with

her lack of symptoms of an ST elevation myocardial infarction and the absence of physical examination findings suggestive of an ST elevation myocardial infarction, I determined, based on my medical training and expertise, that the most prudent course of action in light of the infectious disease protocols at that time given the COVID-19 treatment environment was to delay Ms. Mills's admission to the Cath Lab pending receipt of the results of a COVID-19 test that was administered to her shortly after her arrival to Hartford Hospital.

Asad Rizvi, M.D.

STATE OF CONNECTICUT:

:

COUNTY OF HARTFORD :

Subscribed and sworn to before me
this 13th day of January, 2021.

Darlene R Rolma

~~Commissioner of the Superior Court~~
Notary Public
My Commission Expires: 9/30/2025

DOCKET NO.: HHD CV20 6134761 S	:	SUPERIOR COURT
	:	
ESTATE OF CHERYL D. MILLS	:	J.D. OF HARTFORD
	:	
V.	:	AT HARTFORD
	:	
HARTFORD HEALTHCARE CORP., ET AL.	:	JANUARY 12, 2021

AFFIDAVIT

I, Melissa Ferraro-Borgida, MD, being duly sworn, depose and say that:

1. I am over the age of eighteen years and believe in the obligation of an oath.
2. I am board-certified in cardiovascular disease and a licensed physician in the State of Connecticut, and had privileges to provide care and treatment to patients at Hartford Hospital during the time frame at issue in this lawsuit.
3. I make this affidavit in support of the defendants' motion to dismiss the complaint filed by Kristin Mills, Administrator of the Estate of Cheryl Mills, in the above-captioned action. This affidavit is based on my own personal knowledge, as well as my review of certain medical records produced during or otherwise relating to the treatment period at issue in this lawsuit.
4. I am familiar with the treatment of Cheryl Mills ("Ms. Mills") from March 21, 2020 through March 25, 2020 (the "Treatment Period") because I was involved in Ms. Mills' care at Hartford Hospital on March 21, 2020 and the early morning hours of March 22, 2020. I have also reviewed Ms. Mills'

medical records that were produced during the Treatment Period.

5. At the time of my care and treatment of Ms. Mills, the COVID-19 pandemic was affecting the diagnosis and management of cardiovascular disease patients. My assessment, differential diagnosis, and care and treatment of Ms. Mills was significantly impacted and directed by the COVID-19 pandemic.

6. During the Treatment Period, patients were presenting with suspected COVID-19 related myocarditis simulating an ST Elevation Myocardial Infarction ("STEMI"), thus creating novel diagnostic and therapeutic challenges for patient assessment (myocarditis is an inflammation of the heart muscle usually caused by a viral infection). This was particularly true in patients like Ms. Mills presenting with sore throat and headache and not chest pain and shortness of breath.

7. Additional concerns had to be factored when making treatment decisions for patients during the Treatment Period, including Ms. Mills, because of the COVID-19 pandemic, such as the conservation of personal protective equipment ("PPE") and preventing the spread of COVID-19 to other patients or to staff, which could have caused a compromise of the health of both patients and staff as well as a workforce shortage.

8. The medical records indicate that Ms. Mills first presented to Backus

Hospital on March 21, 2020 with complaints of a 3-day history of sore throat and headache, and the attending emergency room physician sought to have Ms. Mills transferred to Hartford Hospital due to concerns relating to Ms. Mills' electrocardiogram.

9. The medical records indicate at the time of Ms. Mills' admission to Hartford Hospital on March 21, 2020, she was examined by Dr. Asad Rizvi, who suspected that Ms. Mills may have been infected with COVID-19 and that her presentation was consistent with a COVID-19 induced myocarditis. The plan in place at the time I became involved in Ms. Mills' care was to defer cardiac catheterization until receipt of the pending COVID-19 test results.

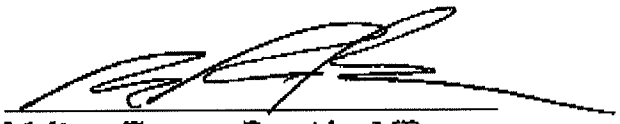
10. Based upon multiple factors including but not limited to my assessment of Ms. Mills on March 21 and 22, 2020, the timing of the assessment, and the patient's history, presentation, symptoms, and test results I, in good faith, agreed with the plan to defer cardiac catheterization until a COVID-19 infection was ruled out as is detailed in my contemporaneously created notes of March 21 and 22, 2020 which are attached hereto.

11. COVID-19 was a primary factor in my diagnostic assessment of COVID-19 caused myocarditis versus acute coronary syndrome.

12. The medical records indicate that on March 21, 2020 at approximately 5:18 pm, a polymerase chain reaction ("PCR") COVID-19 test was administered

to Ms. Mills, and the collected specimen was sent to the Connecticut Department of Public Health for testing.

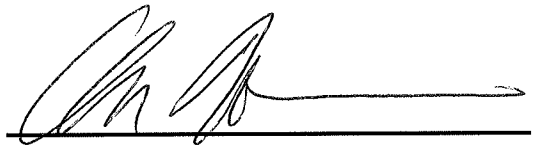
13. The medical records indicate that Ms. Mills' COVID-19 test results were not received until March 24, 2020 at approximately 7:40 P.M, at which time the test indicated a negative result for COVID-19.



Melissa Ferraro-Borgida, MD

STATE OF CONNECTICUT)
) ss. _____
COUNTY OF)

Subscribed and sworn to before me, this 12th day of January, 2021



~~Notary Public~~
~~My Commission Expires:~~
Commissioner of the Superior Court

DOCKET NO.: HHD CV20 6134761 S	:	SUPERIOR COURT
ESTATE OF CHERYL D. MILLS	:	J.D. OF HARTFORD
V.	:	AT HARTFORD
HARTFORD HEALTHCARE CORP., ET AL.	:	JANUARY 12, 2021

AFFIDAVIT

I, **Brett H. Duncan, MD**, being duly sworn, depose and say that:

1. I am over the age of eighteen years and believe in the obligation of an oath.
2. I am board-certified in cardiovascular disease and a licensed physician in the State of Connecticut, and had privileges to provide care and treatment to patients at Hartford Hospital during the timeframe at issue in this lawsuit.
3. I make this affidavit in support of the defendants' motion to dismiss the complaint filed by Kristin Mills, Administrator of the Estate of Cheryl Mills, in the above-captioned action. This affidavit is based on my own personal knowledge, as well as my review of certain medical records produced during or otherwise relating to the treatment period at issue in this lawsuit.
4. I am familiar with the treatment of Cheryl Mills ("Ms. Mills") from

March 21, 2020 through March 22, 2020 because I was involved in Ms. Mills' care at Hartford Hospital on March 22, 2020 (the "Treatment Period").

5. At the time of my care and treatment of Ms. Mills, the COVID-19 pandemic was affecting the diagnosis and management of cardiovascular disease patients. My assessment, differential diagnosis, and care and treatment of Ms. Mills was significantly impacted and directed by the COVID-19 pandemic.

6. During the Treatment Period, patients were presenting with suspected COVID-19 related myocarditis simulating an ST Elevation Myocardial Infarction ("STEMI"), thus creating novel diagnostic and therapeutic challenges for patient assessment (myocarditis is an inflammation of the heart muscle usually caused by a viral infection). This was particularly true in patients like Ms. Mills presenting with sore throat and headache and not chest pain and shortness of breath.

7. On or about March 22, 2020, additional concerns had to be factored when making treatment decisions for patients, including Ms. Mills, because of the COVID-19 pandemic, such as the conservation of personal protective equipment ("PPE") and preventing the spread of COVID-19 to other

patients or to staff, which could have caused a compromise of the health of both patients and staff as well as a workforce shortage.

8. The medical records indicate that Ms. Mills first presented to Backus Hospital on March 21, 2020 with complaints of a 3-day history of sore throat and headache, and the attending emergency room physician sought to have Ms. Mills transferred to Hartford Hospital due to concerns relating to Ms. Mills' electrocardiogram.

9. The medical records indicate at the time of Ms. Mills' admission to Hartford Hospital on March 21, 2020, she was examined by Dr. Asad Rizvi, who suspected that Ms. Mills may have been infected with COVID-19 and that her presentation was consistent with a COVID-19 induced myocarditis. The plan in place at the time I became involved in Ms. Mills' care was to defer cardiac catheterization until receipt of the pending COVID-19 test results.

10. Based upon multiple factors including, but not limited to, my examination and assessment of Ms. Mills on March 22, 2020, the timing of the assessment, and Ms. Mills' history, presentation, symptoms, and test results, I, in good faith, agreed with the plan to defer cardiac catheterization until a COVID-19 infection was ruled out as is detailed in

my contemporaneously created note of March 22, 2020 which is attached hereto.

11. COVID-19 was a primary factor in my diagnostic assessment of COVID-19 caused myocarditis versus acute coronary syndrome.

12. The medical records indicate that on March 21, 2020 at approximately 5:18 pm, a polymerase chain reaction ("PCR") COVID-19 test was administered to Ms. Mills, and the collected specimen was sent to the Connecticut Department of Public Health for testing.

Brett H. Duncan, MD

STATE OF CONNECTICUT)
) ss. _____
COUNTY OF)

Subscribed and sworn to before me, this 12th day of January, 2021.

~~Notary Public~~
~~My Commission Expires~~:
Commissioner of the Superior Court

DOCKET # HHD-CV20-6134761-S	:	SUPERIOR COURT
	:	
KRISTIN MILLS, ADMINISTRATOR OF THE ESTATE OF CHERYL MILLS,	:	J.D. OF HARTFORD
Plaintiff,	:	
	:	
v.	:	AT HARTFORD
	:	
HARTFORD HEALTHCARE CORPORATION, d/b/a HARTFORD HOSPITAL; ASAD RIZVI, M.D.; MELISSA FERRARO-BORGIDA, M.D.; BRETT H. DUNCAN, M.D.; and WILLIAM FARRELL, M.D.,	:	
Defendants.	:	JANUARY 12, 2021

AFFIDAVIT OF DR. ADAM STEINBERG

I, Adam Steinberg, D.O., being duly sworn, depose and state:

1. I am over the age of eighteen (18) and understand the obligations of an oath.

2. I am a physician licensed to provide health care services in the State of Connecticut. I am currently Vice President for Medical Affairs, Hartford Region at Hartford HealthCare Corporation.

3. I make this affidavit in support of Hartford HealthCare Corporation d/b/a Hartford's Hospital's and Dr. Asad Rizvi's motion to dismiss the complaint filed by Kristin Mills, Administrator of the Estate of Cheryl Mills, in the above-captioned action. This affidavit is based on my own personal knowledge, as well as my review of certain medical records produced during or otherwise relating to the treatment period at issue in this lawsuit.

4. I am familiar with the treatment of Cheryl Mills ("Ms. Mills") from March 21, 2020 through March 25, 2020 (the "Treatment Period") and have reviewed Ms. Mills's medical records that were produced during the Treatment Period.

5. At all times relevant to this action, including the Treatment Period, Hartford

HealthCare Corporation, including all of its affiliated hospitals and its agents and employees, was providing health care services in support of the State of Connecticut's response to the ongoing global pandemic caused by the SARS-CoV-2 virus and the associated respiratory illness known as COVID-19. Such response included treating patients infected with or suspected of being infected with COVID-19, as well as taking steps to prevent or limit the spread of COVID-19 to patients receiving treatment for other conditions.

6. During the Treatment Period, the northeastern United States, including Connecticut, was confronted with rapidly-increasing numbers of individuals infected with COVID-19.

7. During the Treatment Period, HHC was engaged in various steps to conserve personal protective equipment ("PPE"), including, but not limited to, minimizing in-person contact between patients and hospital personnel and limiting the number of hospital personnel in contact with patients suspected of having COVID-19.

8. As a result of COVID-19 concerns generally as well as PPE-related concerns specifically, HHC modified its protocols to, among other things, 1) avoid administration of echocardiograms to patients who did not demonstrate an absolute clinical need and 2) avoid admitting patients who were suspected of having COVID-19 to Hartford Hospital's Cardiac Catheterization lab (the "Cath Lab") until they had tested negative, unless their physical symptoms dictated the need for emergency catheterization.

9. Ms. Mills's medical records indicate that she presented to the Backus Hospital Emergency Department (the "Backus ED") on March 21, 2020, complaining of a sore throat and a headache, both of which had lasted approximately three days, and stating that her granddaughter was recently ill with strep throat. A true and accurate copy of this record is

attached hereto as Exhibit A.

10. Ms. Mills's medical records further indicate that, at the time she presented to the Backus ED at the outset of the Treatment Period, she was an employee of the Backus ED. A true and accurate copy of one such record is attached hereto as Exhibit B.

11. Ms. Mills's medical records indicate that Ms. Mills's treating physician in the Backus ED contacted Dr. Asad Rizvi, who was at that time the on-call attending physician in the Cath Lab, due to concerns relating to Ms. Mills's electrocardiogram (EKG) results and to coordinate possible transfer to Hartford Hospital. *See* Exhibit A.

12. Ms. Mills's medical records indicate, among other things, that Dr. Rizvi was concerned that Ms. Mills may have been infected with COVID-19. *See* Exhibits A, B.

13. Ms. Mills's medical records indicate that for multiple reasons, including but not limited to suspicion that she was experiencing a viral syndrome, Dr. Rizvi recommended that Ms. Mills be transferred from the Backus ED to the Hartford Hospital Emergency Department, rather than sent directly to the Cath Lab. *See* Exhibits A, B.

14. Ms. Mills's medical records further indicate that, given her clinical presentation, it was recommended that she be placed in isolation upon her arrival to Hartford Hospital and that any possible COVID-19 infection be ruled out. *See* Exhibit B.

15. Ms. Mills's medical records indicate that, following her arrival to Hartford Hospital, she was given a clinical test for COVID-19 at approximately 5:18 P.M. on March 21, 2020. This test was sent for analysis to the Connecticut State Public Health Laboratory, pursuant to testing protocols then in place. A true and accurate copy of this record is attached hereto as Exhibit C.

16. Ms. Mills's medical records indicate that her COVID-19 test results did not come

back until March 24, 2020 at approximately 7:40 P.M, at which time the test indicated a negative result for COVID-19. A true and accurate copy of this record is attached as Exhibit D.

Adam Steinberg, D.O.
Vice President for Medical Affairs, Hartford Region
at Hartford HealthCare Corp.

STATE OF CONNECTICUT :

COUNTY OF HARTFORD :

Subscribed and sworn to before me
this 12th day of January, 2021.

Commissioner of the Superior Court
Notary Public
My Commission Expires:

ANNA JARNUTOWSKI
NOTARY PUBLIC - CT 178195
MY COMMISSION EXPIRES JANUARY 31, 2024

AFFIDAVIT

I, Emil R. Hayek, being duly sworn, depose and say the following:

1. I am over the age of eighteen (18) and believe in the obligation of an oath.

2. I am a board certified in Cardiovascular Disease, Nuclear Cardiology, Echocardiology and Internal Medicine in a State requiring the same or greater qualifications as the State of Connecticut for such certifications

3. In relation to the case of the Estate of Cheryl Mills, I have reviewed the records from Backus Hospital of March 21, 2020 and the records of Hartford Hospital from March 21, 2020 through March 25, 2020.

4. On March 21, 2020, Cheryl Mills was suffering an acute STEMI.

5. On March 21, 2020, the attending cardiologist at Hartford Hospital misdiagnosed Ms. Mills with myopericarditis.

6. From March 21, 2020 through March 24, 2020, attending physicians at Hartford Hospital continued to diagnose Ms. Mills with myopericarditis and/or myocarditis and deferred transfers to the cardiac catheterization unit ("Cath Lab").

7. Myopericarditis and myocarditis are not life-threatening emergencies requiring immediate treatment in the Cath Lab.

8. The standard of care for treating patients suffering from myopericarditis and myocarditis is supportive medical care.

9. The standard of care for treating patients suffering an acute STEMI is primary percutaneous coronary intervention in the Cath Lab with a goal "door-to-balloon" time of less than 90 minutes, and appropriate monitoring.

10. During the COVID-19 pandemic, the standard treatment for STEMIs has not changed, and patients suffering an acute STEMI are seen on an emergent basis in the Cath Lab regardless of their COVID-19 status for primary percutaneous coronary intervention.

I, Emil R. Hayek, hereby attest that the above statements are true and accurate to the best of my knowledge and belief.

EMIL R. HAYEK

STATE OF OHIO)
) ss: Hudson January 26, 2021
COUNTY OF SUMMIT)

Subscribed and sworn before me this 26th day of January, 2021

ABBY BROWN-DONGES
NOTARY PUBLIC
FOR THE
STATE OF OHIO
My Commission Expires
June 17, 2023

Notary Public
My Commission Expires:

STATE OF CONNECTICUT

BY HIS EXCELLENCY

NED LAMONT

EXECUTIVE ORDER NO. 7U

PROTECTION OF PUBLIC HEALTH AND SAFETY DURING COVID-19 PANDEMIC AND RESPONSE – PROTECTIONS FROM CIVIL LIABILITY FOR HEALTHCARE PROVIDERS AND BILLING PROTECTIONS FOR PATIENTS

WHEREAS, on March 10, 2020, I issued a declaration of public health and civil preparedness emergencies, proclaiming a state of emergency throughout the State of Connecticut as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed spread in Connecticut; and

WHEREAS, pursuant to such declaration, I have issued twenty-one (21) executive orders to suspend or modify statutes and to take other actions necessary to protect public health and safety and to mitigate the effects of the COVID-19 pandemic; and

WHEREAS, COVID-19 is a respiratory disease that spreads easily from person to person and may result in serious illness or death; and

WHEREAS, the World Health Organization has declared the COVID-19 outbreak a pandemic; and

WHEREAS, the risk of severe illness and death from COVID-19 appears to be higher for individuals who are 60 years of age or older and for those who have chronic health conditions; and

WHEREAS, to reduce the spread of COVID-19, the United States Centers for Disease Control and Prevention and the Connecticut Department of Public Health recommend implementation of community mitigation strategies to increase containment of the virus and to slow transmission of the virus, including cancellation of gatherings of ten people or more and social distancing in smaller gatherings; and

WHEREAS, Section 38a-477aa of the Connecticut General Statutes addresses health care provider reimbursements for emergency services and surprise bills; and

WHEREAS, Sections 19a-508c(l) of the Connecticut General Statutes addresses hospital reimbursements for facility fees; and

WHEREAS, Section 19a-673 of the Connecticut General Statutes addresses maximum hospital charge amounts for uninsured patients; and

WHEREAS, in order to respond adequately to the public health emergency posed by the COVID-19 pandemic, it has been necessary to supplement Connecticut's health care workforce and the capacity of health care facilities to deliver life-saving care by requesting the assistances of health care professionals who have not previously maintained liability coverage; facilitating the deployment of volunteer and out-of-state healthcare professionals; and calling upon healthcare professionals to perform acts that they would not perform in the ordinary course of business; and

WHEREAS, in order to encourage maximum participation in efforts to expeditiously expand Connecticut's health care workforce and facilities capacity, there exists a compelling state interest in affording such professionals and facilities protection against liability for good faith actions taken in the course of their significant efforts to assist in the state's response to the current public health and civil preparedness emergency; and

WHEREAS, no Connecticut resident should have to choose between health and their financial security; and

WHEREAS, health insurance carriers anticipate future health expenditures in their plan design, including premium and cost-sharing allocations, but the current public health emergency will result in significant unexpected health care costs to consumers and health carriers; and

WHEREAS, it is in the public interest to mitigate the adverse impact on consumers' financial security that may result from treatment for COVID-19, as well as to limit the likely premium increases facing consumers in 2021 as a result of the COVID-19 response;

NOW, THEREFORE, I, NED LAMONT, Governor of the State of Connecticut, by virtue of the authority vested in me by the Constitution and the laws of the State of Connecticut, do hereby **ORDER AND DIRECT:**

1. **Protection from Civil Liability for Actions or Omissions in Support of the State's COVID-19 Response.** Notwithstanding any provision of the Connecticut General Statutes, or any associated regulations, rules, policies, or procedures, any health care professional or health care facility shall be immune from suit for civil liability for any injury or death alleged to have been sustained because of the individual's or health care facility's acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response, including but not limited to acts or omissions undertaken because of a lack of resources, attributable to the COVID-19 pandemic, that renders the health care professional or health care facility unable to provide the level or manner of care that otherwise would have been required in the absence of the COVID-19 pandemic and which resulted in the damages at issue, provided that nothing in this order shall remove or limit any immunity conferred by any provision of the Connecticut General Statutes or other law. Such immunity shall not extend to acts or omissions that constitute a crime, fraud, malice, gross negligence, willful misconduct, or would otherwise constitute a false claim or prohibited act pursuant to Section 4-275 et seq.

of the Connecticut General Statutes or 31 U.S.C. §§3729 et seq. The term "health care professional" means an individual who is licensed, registered, permitted, or certified in any state in the United States to provide health care services and any retired professional, professional with an inactive license, or volunteer approved by the Commissioner of the Department of Public Health or her designee. The term "health care facility" means a licensed or state approved hospital, clinic, nursing home, field hospital or other facility designated by the Commissioner of the Department of Public Health for temporary use for the purposes of providing essential services in support of the State's COVID-19 response. The immunity conferred by this order applies to acts or omissions subject to this order occurring at any time during the public health and civil preparedness emergency declared on March 10, 2020, including any period of extension or renewal, including acts or omissions occurring prior to the issuance of this order attributable to the COVID-19 response effort.

2. **Financial Protections for the Uninsured and People Covered by Insurance Who Receive Out-of-Network Health Care Services During the Public Health Emergency.** Effective immediately and for the duration of the public health and civil preparedness emergency declared on March 10, 2020, including any period of extension or renewal:

    a. Section 38a-477aa(b)(3)(A) of the Connecticut General Statutes is modified to provide: "If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall reimburse such health care provider the amount the insured's health care plan would pay for such services if rendered by an in-network health care provider as payment in full."

    b. Section 38a-477aa(b)(3)(B) of the Connecticut General Statutes is suspended.

    c. Section 19a-673(b) of the Connecticut General Statutes is modified to provide: "No hospital that has provided health care services to an uninsured patient may collect from the uninsured patient more than the cost of providing services, except that, for uninsured patients receiving services for the treatment and management of COVID-19, no hospital may collect from the uninsured patient or such patient's estate more than the Medicare rate for said services as payment in full."

    d. Section 19a-508c(l) of the Connecticut General Statutes is modified to additionally provide: "Notwithstanding the provisions of this section, no hospital, health system or hospital-based facility shall collect a facility fee

for services received by a patient for the treatment and management of COVID-19 who is uninsured of more than the Medicare rate."

e. No hospital shall bill any individual not otherwise covered by any public or private health plan for services received for treatment and management of COVID-19, unless and until clarified by further executive order regarding distribution of any federal funding that may be made available to cover such services.

f. Each hospital, health system or hospital-based facility shall maintain fiscal records to identify services provided to uninsured patients for treatment and management of COVID-19 and make such records available for claiming federal reimbursement, as applicable.

Unless otherwise specified herein, this order shall take effect immediately and shall remain in effect for the duration of the public health and civil preparedness emergency, unless earlier modified or terminated by me.

Dated at Hartford, Connecticut, this 5th day of April, 2020.

Ned Lamont
Governor

By His Excellency's Command

Denise W. Merrill
Secretary of the State

STATE OF CONNECTICUT

BY HIS EXCELLENCY

NED LAMONT

EXECUTIVE ORDER NO. 7V

PROTECTION OF PUBLIC HEALTH AND SAFETY DURING COVID-19 PANDEMIC AND RESPONSE – SAFE WORKPLACES, EMERGENCY EXPANSION OF THE HEALTHCARE WORKFORCE

WHEREAS, on March 10, 2020, I issued a declaration of public health and civil preparedness emergencies, proclaiming a state of emergency throughout the State of Connecticut as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed spread in Connecticut; and

WHEREAS, pursuant to such declaration, I have issued twenty-two (22) executive orders to suspend or modify statutes and to take other actions necessary to protect public health and safety and to mitigate the effects of the COVID-19 pandemic; and

WHEREAS, COVID-19 is a respiratory disease that spreads easily from person to person and may result in serious illness or death; and

WHEREAS, the World Health Organization has declared the COVID-19 outbreak a pandemic; and

WHEREAS, the risk of severe illness and death from COVID-19 appears to be higher for individuals who are 60 years of age or older and for those who have chronic health conditions; and

WHEREAS, to reduce the spread of COVID-19, the United States Centers for Disease Control and Prevention and the Connecticut Department of Public Health recommend implementation of community mitigation strategies to increase containment of the virus and to slow transmission of the virus, including cancellation of gatherings of ten people or more and social distancing in smaller gatherings; and

WHEREAS, the critical need to limit the spread of COVID-19 requires the enforcement of distancing and other protective measures in all workplaces; and

WHEREAS, numerous medical professionals, after having completed the educational requirements for their profession, are permitted to temporarily practice their profession under the supervision of a licensed practitioner prior to being licensed; and

WHEREAS, such professionals' ability to temporarily practice their profession may expire prior to the end of the public health and civil preparedness emergency; and

WHEREAS, necessary public health protective measures enacted in response to the COVID-19 pandemic may prevent such professionals from completing their licensing requirements during the public health and civil preparedness emergency; and

WHEREAS, to maintain and expand the healthcare workforce capacity for COVID-19 response and mitigation efforts, it is necessary to allow such professionals to continue to work in such temporary, supervised status for the duration of the declared civil preparedness and public health emergency; and

WHEREAS, as a result of the dire economic effects of the necessary public health protective measures enacted in response to the COVID-19 pandemic, an unprecedented number of Connecticut residents have filed for unemployment benefits; and

WHEREAS, to reduce burdens on contributing employers whose employees have had to file unemployment claims as a result of COVID-19, it is necessary to relieve those employers of the amount of benefit payments charged to an employer's experience account; and

WHEREAS, there exists a compelling state interest in rapidly expanding the capacity of health care professionals and facilities to provide care during the COVID-19 pandemic; and

WHEREAS, providing relief from liability for such health care professionals for good faith efforts to provide care during the COVID-19 pandemic will greatly increase the state's ability to achieve such an expansion;

NOW, THEREFORE, I, NED LAMONT, Governor of the State of Connecticut, by virtue of the authority vested in me by the Constitution and the laws of the State of Connecticut, do hereby **ORDER AND DIRECT:**

1. **Safe Workplaces in Essential Businesses.** Every workplace in the State of Connecticut shall take additional protective measures to reduce the risk of transmission of COVID-19 between and among employees, customers, and other persons such as delivery drivers, maintenance people or others who may enter the workplace. The Commissioner of Economic and Community Development, in consultation with the Commissioner of Public Health, shall issue legally binding statewide rules prescribing such additional protective measures no later than 5:00 p.m. on April 7, 2020. Such rules shall be mandatory throughout the state, for essential businesses and nonprofits and any other business or nonprofit permitted to operate, and shall supersede and preempt any current or future municipal order. Nothing in such rules or this order shall supersede Executive Order No. 7S, Section 1, or the "Safe Stores" rules promulgated thereunder.

2. **Temporary Permits for Certain Health Care Providers Extended and Fees Waived.** Sections 20-65k, 20-12b(b), 20-74d, 20-162o(c) and 20-195t of the Connecticut General Statutes are modified to waive any application fees for temporary permits and to extend the duration of the temporary permits for the health care professions governed thereunder (Athletic Trainer, Respiratory Care Practitioner, Physician Assistant, Occupational, Therapist/Assistants, Master Social Worker), for

the duration of the public health and civil preparedness emergency, unless earlier modified or terminated. The Commissioner may issue any implementing order she deems necessary to effectuate this order.

3. **Practice Before Licensure for Certain Health Care Profession Applicants and Graduates.** The provisions in Sections 20-70(b)(1), 20-70(b)(2), 20-74bb(f), and 20-101 of the Connecticut General Statutes that permit practice prior to licensure by applicants and graduates for the health care professions governed thereunder (Physical Therapist, Physical Therapy Assistant, Radiographer, Registered Nurse, Nurse Practitioner, Clinical Nurse Specialist, Nurse Anesthetist), are modified to permit such practice for the duration of the public health and civil preparedness emergency, unless earlier modified or terminated. The Commissioner of Public Health may issue any implementing orders she deems necessary to effectuate this order.

4. **Practice Before Licensure for Marital and Family Therapy Associates.** Section 20-195f of the Connecticut General Statutes is modified to provide that, for the duration of the public health and civil preparedness emergency, unless earlier modified or terminated, no license shall be required to practice as a marital and family therapy associate, as defined in Section 20-195a(4), for a person who has completed a graduate degree program specializing in marital and family therapy offered by a regionally accredited institution of higher education or a postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education and offered by a regionally accredited institution of higher education. The Commissioner may issue any implementing orders she deems necessary to effectuate this order.

5. **Practice Before Licensure for Professional Counselor Associates.** Section 20-195bb(c) of the Connecticut General Statutes is modified to permit a person who has completed the requirements in Section 20-195dd(b) to practice as a professional counselor associate without obtaining a license for the duration of the public health and civil preparedness emergency, unless earlier modified or terminated. The Commissioner may issue any implementing orders she deems necessary to effectuate this order.

6. **Executive Order No. 7U, Section 1, Superseded - Protection from Civil Liability for Actions or Omissions in Support of the State's COVID-19 Response.** Section 1 of my prior Executive Order No. 7U concerning protection from civil liability for actions or omissions in support of the State's COVID-19 response is hereby superseded and replaced in its entirety by the following:

   Notwithstanding any provision of the Connecticut General Statutes or any other state law, including the common law, or any associated regulations, rules, policies, or procedures, any health care professional or health care facility shall be immune from suit for civil liability for any injury or death alleged to have been sustained because of the individual's or health care facility's acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response, including

but not limited to acts or omissions undertaken because of a lack of resources, attributable to the COVID-19 pandemic, that renders the health care professional or health care facility unable to provide the level or manner of care that otherwise would have been required in the absence of the COVID-19 pandemic and which resulted in the damages at issue, provided that nothing in this order shall remove or limit any immunity conferred by any provision of the Connecticut General Statutes or other law. Such immunity shall not extend to acts or omissions that constitute a crime, fraud, malice, gross negligence, willful misconduct, or would otherwise constitute a false claim or prohibited act pursuant to Section 4-275 et seq. of the Connecticut General Statutes or 31 U.S.C. §§3729 et seq. The term "health care professional" means an individual who is licensed, registered, permitted, or certified in any state in the United States to provide health care services and any retired professional, professional with an inactive license, or volunteer approved by the Commissioner of the Department of Public Health or her designee. The term "health care facility" means a licensed or state approved hospital, clinic, nursing home, field hospital or other facility designated by the Commissioner of the Department of Public Health for temporary use for the purposes of providing essential services in support of the State's COVID-19 response. The immunity conferred by this order applies to acts or omissions subject to this order occurring at any time during the public health and civil preparedness emergency declared on March 10, 2020, including any period of extension or renewal, including acts or omissions occurring prior to the issuance of this order attributable to the COVlD-19 response effort.

Unless otherwise specified herein, this order shall take effect immediately and shall remain in effect for the duration of the public health and civil preparedness emergency, unless earlier modified or terminated by me.

Dated at Hartford, Connecticut, this 7th day of April, 2020.

Ned Lamont
Governor

By His Excellency's Command

Denise W. Merrill
Secretary of the State

Relevant Rules and Statutes

Three asterisks (* * *) represent omission, in interest of space, of provisions not referenced in brief.

Practice Book § 10-30. Motion to Dismiss; Grounds

(a) A motion to dismiss shall be used to assert: (1) lack of jurisdiction over the subject matter; (2) lack of jurisdiction over the person; (3) insufficiency of process; and (4) insufficiency of service of process.

(b) Any defendant, wishing to contest the court's jurisdiction, shall do so by filing a motion to dismiss within thirty days of the filing of an appearance.

(c) This motion shall always be filed with a supporting memorandum of law and, where appropriate, with supporting affidavits as to facts not apparent on the record.

General Statutes § 7-294u. State and local police training re use of opioid antagonist. Maintaining supply of and carrying opioid antagonists

(a) As used in this section, (1) “law enforcement unit” and “police officer” have the same meanings as provided in section 7-294a, and (2) “opioid antagonist” has the same meaning as provided in section 17a-714a.

(b) Each law enforcement unit shall (1) require its police officers to receive training in the use of an opioid antagonist, and (2) acquire and maintain a supply of opioid antagonists for use by its police officers when responding to a medical emergency. Any police officer who completes such training shall be permitted to carry and administer an opioid antagonist to an individual whom the officer believes in good faith is experiencing an opioid-related drug overdose.

General Statutes § 19a-909. Access to and maintenance and administration of epinephrine cartridge injectors by authorized entities. Limitation on liability

* * *

(d) A person with training who is an employee or agent of an authorized entity that acquires and maintains a supply of epinephrine cartridge injectors pursuant to subsection (c) of this section may, in accordance with the established medical protocol, (1) provide an epinephrine cartridge injector to an individual or to the parent, guardian or caregiver of an individual, whom the person with training believes in good faith is experiencing anaphylaxis, regardless of whether the

individual has a prescription for an epinephrine cartridge injector or a prior medical diagnosis of an allergic condition, for the purpose of immediate administration of such epinephrine cartridge injector by such individual, parent, guardian or caregiver, or (2) administer an epinephrine cartridge injector to an individual whom the person with training believes in good faith is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine cartridge injector or a prior medical diagnosis of an allergic condition. The person with training or any other employee or agent of the authorized entity shall promptly notify a local emergency medical services organization after any administration of an epinephrine cartridge injector acquired and maintained by the authorized entity.

* * *

(f) (1) A prescribing practitioner who is authorized to prescribe epinephrine may establish a medical protocol with an authorized entity in accordance with this section without being liable for damages in a civil action or subject to criminal prosecution for establishing such medical protocol or for any subsequent use of an epinephrine cartridge injector acquired and maintained by the authorized entity under this section. A prescribing practitioner who has established a medical protocol with an authorized entity in accordance with the provisions of this section shall be deemed not to have violated the standard of care for such licensed health care provider.

(2) A person with training or an authorized entity that employs or has an agent who is a person with training who provides or administers an epinephrine cartridge injector to an individual whom the person with training believes in good faith is experiencing anaphylaxis in accordance with the provisions of this section shall not be liable to such individual for civil damages or subject to criminal prosecution for any personal injuries that result from acts or omissions by such person with training in using an epinephrine cartridge injector, which may constitute ordinary negligence. The immunity provided in this subsection shall not apply to wilful or wanton misconduct or acts or omissions constituting gross negligence.

* * *

General Statutes § 28-9. Civil preparedness or public health emergency; Governor's powers. Modification or suspension of statutes, regulations or other requirements

(a) In the event of serious disaster, enemy attack, sabotage or other hostile action or in the event of the imminence thereof, the Governor may proclaim that a state of civil preparedness emergency exists, in which event the Governor may personally take direct operational control of any or all parts of the civil

preparedness forces and functions in the state. Any such proclamation shall be effective upon filing with the Secretary of the State. Any such proclamation, or order issued pursuant thereto, issued by the Governor because of a disaster resulting from man-made cause may be disapproved by majority vote of a joint legislative committee consisting of the president pro tempore of the Senate, the speaker of the House of Representatives and the majority and minority leaders of both houses of the General Assembly, provided at least one of the minority leaders votes for such disapproval. Such disapproval shall not be effective unless filed with the Secretary of the State not later than seventy-two hours after the filing of the Governor's proclamation with the Secretary of the State. As soon as possible after such proclamation, if the General Assembly is not then in session, the Governor shall meet with the president pro tempore of the Senate, the speaker of the House of Representatives, and the majority and minority leaders of both houses of the General Assembly and shall confer with them on the advisability of calling a special session of the General Assembly.

(b) Upon such proclamation, the following provisions of this section and the provisions of section 28-11 shall immediately become effective and shall continue in effect until the Governor proclaims the end of the civil preparedness emergency:

(1) Following the Governor's proclamation of a civil preparedness emergency pursuant to subsection (a) of this section or declaration of a public health emergency pursuant to section 19a-131a, the Governor may modify or suspend in whole or in part, by order as hereinafter provided, any statute, regulation or requirement or part thereof whenever the Governor finds such statute, regulation or requirement, or part thereof, is in conflict with the efficient and expeditious execution of civil preparedness functions or the protection of the public health. The Governor shall specify in such order the reason or reasons therefor and any statute, regulation or requirement or part thereof to be modified or suspended and the period, not exceeding six months unless sooner revoked, during which such order shall be enforced. Any such order shall have the full force and effect of law upon the filing of the full text of such order in the office of the Secretary of the State. The Secretary of the State shall, not later than four days after receipt of the order, cause such order to be printed and published in full in at least one issue of a newspaper published in each county and having general circulation therein, but failure to publish shall not impair the validity of such order. Any statute, regulation or requirement, or part thereof, inconsistent with such order shall be inoperative for the effective period of such order. Any such order shall be communicated by the Governor at the earliest date to both houses of the General Assembly.

(2) The Governor may order into action all or any part of the department or local or joint organizations for civil preparedness mobile support units or any other civil preparedness forces.

(3) The Governor shall order and enforce such blackouts and radio silences as are authorized by the United States Army or its duly designated agency and may take any other precautionary measures reasonably necessary in the light of the emergency.

(4) The Governor may designate such vehicles and persons as shall be permitted to move and the routes which they shall follow.

(5) The Governor shall take appropriate measures for protecting the health and safety of inmates of state institutions and children in schools.

(6) The Governor may order the evacuation of all or part of the population of stricken or threatened areas and may take such steps as are necessary for the receipt and care of such evacuees.

(7) The Governor may take such other steps as are reasonably necessary in the light of the emergency to protect the health, safety and welfare of the people of the state, to prevent or minimize loss or destruction of property and to minimize the effects of hostile action.

(8) In order to insure the automatic and effective operation of civil preparedness in the event of enemy attack, sabotage or other hostile action, or in the event of the imminence thereof, the Governor may, at the Governor's discretion, at any time prior to actual development of such conditions, issue such proclamations and executive orders as the Governor deems necessary, such proclamations and orders to become effective only under such conditions.

General Statutes § 52-146c. Privileged communications between psychologist and patient

(a) As used in this section:

(1) “Person” means an individual who consults a psychologist for purposes of diagnosis or treatment;

(2) “Psychologist” means an individual licensed to practice psychology pursuant to chapter 383;1

(3) “Communications” means all oral and written communications and records thereof relating to the diagnosis and treatment of a person between such person and a psychologist or between a member of such person's family and a psychologist;

(4) “Consent” means consent given in writing by the person or his authorized representative;
(5) “Authorized representative” means (A) an individual empowered by a person to assert the confidentiality of communications which are privileged under this section, or (B) if a person is deceased, his personal representative or next of kin, or (C) if a person is incompetent to assert or waive his privileges hereunder, (i) a guardian or conservator who has been or is appointed to act for the person, or (ii) for the purpose of maintaining confidentiality until a guardian or conservator is appointed, the person's nearest relative.

(b) Except as provided in subsection (c) of this section, in civil and criminal actions, in juvenile, probate, commitment and arbitration proceedings, in proceedings preliminary to such actions or proceedings, and in legislative and administrative proceedings, all communications shall be privileged and a psychologist shall not disclose any such communications unless the person or his authorized representative consents to waive the privilege and allow such disclosure. The person or his authorized representative may withdraw any consent given under the provisions of this section at any time in a writing addressed to the individual with whom or the office in which the original consent was filed. The withdrawal of consent shall not affect communications disclosed prior to notice of the withdrawal.

(c) Consent of the person shall not be required for the disclosure of such person's communications:

(1) If a judge finds that any person after having been informed that the communications would not be privileged, has made the communications to a psychologist in the course of a psychological examination ordered by the court, provided the communications shall be admissible only on issues involving the person's psychological condition;

(2) If, in a civil proceeding, a person introduces his psychological condition as an element of his claim or defense or, after a person's death, his condition is introduced by a party claiming or defending through or as a beneficiary of the person, and the judge finds that it is more important to the interests of justice that the communications be disclosed than that the relationship between the person and psychologist be protected;

(3) If the psychologist believes in good faith that there is risk of imminent personal injury to the person or to other individuals or risk of imminent injury to the property of other individuals;

(4) If child abuse, abuse of an elderly individual or abuse of an individual who is disabled or incompetent is known or in good faith suspected;

(5) If a psychologist makes a claim for collection of fees for services rendered, the name and address of the person and the amount of the fees may be disclosed to individuals or agencies involved in such collection, provided notification that such disclosure will be made is sent, in writing, to the person not less than thirty days prior to such disclosure. In cases where a dispute arises over the fees or claims or where additional information is needed to substantiate the claim, the disclosure of further information shall be limited to the following: (A) That the person was in fact receiving psychological services, (B) the dates of such services, and (C) a general description of the types of services; or

(6) If the communications are disclosed to a member of the immediate family or legal representative of the victim of a homicide committed by the person where such person has, on or after July 1, 1989, been found not guilty of such offense by reason of mental disease or defect pursuant to section 53a-13, provided such family member or legal representative requests the disclosure of such communications not later than six years after such finding, and provided further, such communications shall only be available during the pendency of, and for use in, a civil action relating to such person found not guilty pursuant to section 53a-13.

General Statutes § 52-190a. Prior reasonable inquiry and certificate of good faith required in negligence action against a health care provider. Ninety-day extension of statute of limitations

(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action or apportionment complaint has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint, initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. To show the existence of such good faith, the claimant or the claimant's attorney, and any apportionment complainant or the apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion. Such written opinion shall not be subject to discovery by any party except for questioning the validity of the certificate. The claimant or the claimant's attorney,

and any apportionment complainant or apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. The similar health care provider who provides such written opinion shall not, without a showing of malice, be personally liable for any damages to the defendant health care provider by reason of having provided such written opinion. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney or the apportionment complainant's attorney submitted the certificate.

(b) Upon petition to the clerk of any superior court or any federal district court to recover damages resulting from personal injury or wrongful death, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by subsection (a) of this section. This period shall be in addition to other tolling periods.

(c) The failure to obtain and file the written opinion required by subsection (a) of this section shall be grounds for the dismissal of the action.

General Statutes § 52-555. Actions for injuries resulting in death

(a) In any action surviving to or brought by an executor or administrator for injuries resulting in death, whether instantaneous or otherwise, such executor or administrator may recover from the party legally at fault for such injuries just damages together with the cost of reasonably necessary medical, hospital and nursing services, and including funeral expenses, provided no action shall be brought to recover such damages and disbursements but within two years from the date of death, and except that no such action may be brought more than five years from the date of the act or omission complained of.

(b) Notwithstanding the provisions of subsection (a) of this section, an action may be brought under this section at any time after the date of the act or omission complained of if the party legally at fault for such injuries resulting in death has been convicted or found not guilty by reason of mental disease or defect of a

violation of section 53a-54a, 53a-54b, 53a-54c, 53a-54d, 53a-55 or 53a-55a with respect to such death.

General Statutes § 52-557v. Immunity from liability of the state, political subdivisions and employees for emergency administration of epinephrine cartridge injector

(a) A person (1) employed to work for the state or any political subdivision thereof that has acquired and maintains a supply of epinephrine cartridge injectors, (2) who is trained in the use of an epinephrine cartridge injector in accordance with subdivision (2) of subsection (a) of section 19a-909, and (3) provides or administers an epinephrine cartridge injector to an individual whom the person believes in good faith is experiencing anaphylaxis during the course of such person's employment, shall not be liable to such individual for civil damages or subject to criminal prosecution for any personal injuries that result from acts or omissions by such person in using an epinephrine cartridge injector, which may constitute ordinary negligence. The immunity provided in this subsection shall not apply to wilful or wanton misconduct or acts or omissions constituting gross negligence.

(b) The state or any political subdivision thereof that (1) has acquired and maintains a supply of epinephrine cartridge injectors, and (2) employs a person who (A) is trained in the use of an epinephrine cartridge injector in accordance with subdivision (2) of subsection (a) of section 19a-909, and (B) provides or administers an epinephrine cartridge injector to an individual whom the person believes in good faith is experiencing anaphylaxis during the course of such person's employment, shall not be liable to such individual for civil damages for any personal injuries that result from acts or omissions by such person in using an epinephrine cartridge injector, which may constitute ordinary negligence. The immunity provided in this subsection shall not apply to wilful or wanton misconduct or acts or omissions constituting gross negligence.

General Statutes § 52-571k. Action for equitable relief or damages resulting from deprivation of equal protection of the laws of the state committed by a police officer

(a) As used in this section:

(1) “Law enforcement unit” has the same meaning as provided in section 7-294a; and

(2) “Police officer” has the same meaning as provided in section 7-294a.

(b) No police officer, acting alone or in conspiracy with another, shall deprive any person or class of persons of the equal protection of the laws of this state, or of the equal privileges and immunities under the laws of this state, including, without limitation, the protections, privileges and immunities guaranteed under article first of the Constitution of the state.

(c) Any person aggrieved by a violation of subsection (b) of this section may bring a civil action for equitable relief or damages in the Superior Court. A civil action brought for damages shall be triable by jury.

(d)(1) In any civil action brought under this section, governmental immunity shall only be a defense to a claim for damages when, at the time of the conduct complained of, the police officer had an objectively good faith belief that such officer's conduct did not violate the law. There shall be no interlocutory appeal of a trial court's denial of the application of the defense of governmental immunity. Governmental immunity shall not be a defense in a civil action brought solely for equitable relief.

(2) In any civil action brought under this section, the trier of fact may draw an adverse inference from a police officer's deliberate failure, in violation of section 29-6d, to record any event that is relevant to such action.

(e) In an action under this section, each municipality or law enforcement unit shall protect and save harmless any such police officer from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand or suit instituted against such officer by reason of any act undertaken by such officer while acting in the discharge of the officer's duties. In the event such officer has a judgment entered against him or her for a malicious, wanton or wilful act in a court of law, such municipality shall be reimbursed by such officer for expenses it incurred in providing such defense and shall not be held liable to such officer for any financial loss or expense resulting from such act.

(f) In any civil action brought under this section, if the court finds that a violation of subsection (b) of this section was deliberate, wilful or committed with reckless indifference, the plaintiff may be awarded costs and reasonable attorney's fees.

(g) A civil action brought pursuant to this section shall be commenced not later than one year after the date on which the cause of action accrues. Any notice of claim provision set forth in the general statutes, including, but not limited to, the provisions of subsection (d) of section 7-101a and subsection (a) of section 7-465 shall not apply to an action brought under this section.

General Statutes § 52-572h. Negligence actions. Doctrines applicable. Liability of multiple tortfeasors for damages

* * *

(g) (1) Upon motion by the claimant to open the judgment filed, after good faith efforts by the claimant to collect from a liable defendant, not later than one year after judgment becomes final through lapse of time or through exhaustion of appeal, whichever occurs later, the court shall determine whether all or part of a defendant's proportionate share of the recoverable economic damages and recoverable noneconomic damages is uncollectible from that party, and shall reallocate such uncollectible amount among the other defendants in accordance with the provisions of this subsection. (2) The court shall order that the portion of such uncollectible amount which represents recoverable noneconomic damages be reallocated among the other defendants according to their percentages of negligence, provided that the court shall not reallocate to any such defendant an amount greater than that defendant's percentage of negligence multiplied by such uncollectible amount. (3) The court shall order that the portion of such uncollectible amount which represents recoverable economic damages be reallocated among the other defendants. The court shall reallocate to any such other defendant an amount equal to such uncollectible amount of recoverable economic damages multiplied by a fraction in which the numerator is such defendant's percentage of negligence and the denominator is the total of the percentages of negligence of all defendants, excluding any defendant whose liability is being reallocated. (4) The defendant whose liability is reallocated is nonetheless subject to contribution pursuant to subsection (h) of this section and to any continuing liability to the claimant on the judgment.

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42 U.S.C. § 247d-6d. Targeted liability protections for pandemic and epidemic products and security countermeasures

(a) Liability protections

(1) In general
Subject to the other provisions of this section, a covered person shall be immune from suit and liability under Federal and State law with respect to all claims for loss caused by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure if a declaration under subsection (b) has been issued with respect to such countermeasure.

(2) Scope of claims for loss

(A) Loss

For purposes of this section, the term “loss” means any type of loss, including--

(i) death;

(ii) physical, mental, or emotional injury, illness, disability, or condition;

(iii) fear of physical, mental, or emotional injury, illness, disability, or condition, including any need for medical monitoring; and

(iv) loss of or damage to property, including business interruption loss.

Each of clauses (i) through (iv) applies without regard to the date of the occurrence, presentation, or discovery of the loss described in the clause.

(B) Scope
The immunity under paragraph (1) applies to any claim for loss that has a causal relationship with the administration to or use by an individual of a covered countermeasure, including a causal relationship with the design, development, clinical testing or investigation, manufacture, labeling, distribution, formulation, packaging, marketing, promotion, sale, purchase, donation, dispensing, prescribing, administration, licensing, or use of such countermeasure.

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